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Editorial

One [illegible] of Editors of this Journal [illegible] will be sufficient material to form the basis for [illegible] approached me to be. Over the years a number [illegible] encourage authors to submit work for publication [illegible] ention. But I did find myself interested in some interesting [illegible] much to assuage the editorial anxiety. The current [illegible] MOIC INM and Commanding Officer of SpRs and [illegible] that trainees are under pressure to publish their [illegible] their professional portfolios and CVs in readiness for their Armed Services Consultant Approval Board and consultant appointments. Also, how many MSc or other dissertations are written every year? How much of that work is published and where do I would be the first to admit that the Journal may not be the journal of first choice for [illegible] work that is being done at public expense is of interest to a wider audience. I press [illegible] in the right way.

Past journals are a treasure trove of case reports, unusual patients, clinical curio, personal reminiscences. I do not think I am unusual in finding this type of article both interesting and educational; they bring an insight into medical practice in specialties other than one's own and are far more engaging than papers of a more academic bent. They are of major interest only to those in the same specialty or subspecialty and really belong in specialist journals. My last Editorial reflected briefly on the quintessential essence of the Royal Naval Medical Service. We are a diverse and interesting group of medical professionals practising between the NHS and our own military environments. Whether at sea or on land, we cope with all the additional difficulties and clinical issues that military practice brings. I believe that the material is out there, all that has to be done is to put pen to paper (metaphorically speaking these days!).

This edition reflects some of the diversity of that practice. Operation VELA, which took place in West Africa last autumn, is described from both staff and clinical points of view. Their different perspectives bring home the challenges of managing a major evolution over several months and the medical issues which have to be addressed either as part of the plan or as contingencies. They give tantalising glimpses of wider medical issues which I hope will be considered for this journal in due course. No doubt the formal military analysis will identify lessons learnt and will develop mitigating policies.

Endeavours in West Africa also feature in the historic article on William Balfour Baikie, a skilled and widely experienced naval doctor who would appear to have had excellent leadership skills as well. The revelation that he led an expedition several hundred miles up the Niger and Benue Rivers in 1854 without experiencing a single case of malaria I find quite remarkable, especially as the pioneering work by Ross on the transmission of the disease and the life cycle of the parasite responsible had yet to be undertaken. Nevertheless, even in 1854 a great deal was known about malaria and other fevers and their transmission in relation to swamp mists. The use of quinine was also increasing.

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General

Operational Mental Health: A User's guide for medical staff

N Greenberg, T Browne, V Langston, P McAllister

Background

The United Kingdom's Armed Forces undertake a wide variety of tasks which include warfighting, peacekeeping, security maintenance and disaster relief to name but a few. It is hard to think of any military duties, including training exercises, in which there is not a significant risk of exposure to substantial levels of stress. Furthermore the high operational tempo over recent years when taken in conjunction with the ever decreasing numbers of military personnel available to perform the seemingly ever increasing number of tasks further increases the likelihood that service men and women will be subject to psychological pressure. The aim of this paper is to examine the ways that military medical services can assist the chain of command in preparing personnel for operational duties, supporting them whilst they carry out such duties and in bringing them home. The principles described in this paper apply equally to full time and reserve personnel although one must remember that many reservists do not enjoy the same regular and beneficial access to peer support as regulars.

History

During the First World War the link between war and poor mental health was established. In the Second World War the British Army recognised the need to employ subject matter experts (SMEs) to assist them in keeping the fighting force in a good state of psychological health. Both psychiatrists and psychologists were recruited into the Royal Army Medical Corps (RAMC) where they experimented with novel treatments (1) drawing on ideas from psychoanalysis and social psychology. Indeed once the War ended many of the mental health professionals who had served their country went on to make use of the [illegible] their work as civilians. The [illegible] psychiatrists who had served, including Wilfred Bion, Maxwell Jones was very [illegible] that the (2) National Health [illegible] private sector structured [illegible] (3).

Preparing Troops for Operations

Military personnel come from a wide variety [illegible] socioeconomic and educational backgrounds. Taking into account the wide variety of experiences, it is apparent when considering what sort of preparation is required and likely to be effective. Proper preparation of service personnel coupled with effective early treatment and return to duty is a force multiplier (4).

There are numerous factors which are important in terms of effectively preparing deploying personnel some of which are considered below.

Training

The process of recruitment and initial training is designed in part to weed out those individuals who are unlikely to be robust enough to serve usefully in an operational environment. However there are many elements which determine how psychologically hardy and therefore operationally effective an individual is and training is one of them. There is no doubt that rigorous, regular and realistic training is the best psychological preparation. Medical staff should do all they can to ensure that personnel are able to partake in as much of the operationally directed training that their unit is engaged in. Although it may seem [illegible] for caring to allow individuals who are anxious about a particular aspect of a rigorous exercise

[redacted]

Psychoeducation

There is clear evidence (5) [redacted] activity which fosters a culture [redacted] Health awareness by involving [redacted] military community. An educated [redacted] that understands the imperative [redacted] unnecessary medicalisation and stigmatisation is more likely to maintain its psychological fitness and hence its operational capability. Psychoeducation is a term to describe the necessary elements of any preparatory mental health briefing.

Ideally this should be delivered by mental health personnel who are due to deploy with the assembled battlegroup. This allows all the personnel to identify who their specialist mental health support will be in theatre, helping to overcome the stigma of having to identify this to a leader when in theatre. However, if sufficient personnel are not available then any confident medical person can deliver the brief. There are three essential elements to a preparatory psychoeducational brief:

1. Normalisation of anticipatory battle anxiety and post incident distress. The presenter should aim to demystify the normal human responses to stressful circumstances and explain how personnel might distinguish between normal stress reactions and problematic reactions (remembering that distinguishing feature being not the nature of the reaction but instead whether the soldier can function effectively).

2. Practical non-pharmacological self help strategies to deal with the effects of stress. These should include distraction (talking with colleagues), taking exercise, getting sufficient sleep, eating regularly and limiting exposure to unnecessary stressors (such as not volunteering for the extra guard duty when in fact catching up on well needed sleep was possible). The emphasis should be to explain that operational effectiveness is more like a marathon (requiring self pacing) than a sprint.

3. Explanation of the availability of possible sources of support. This should include explaining the role of the medical staff, padres, chain of command and welfare staff. Some units such as the Grenadier Guards may have specially trained peer support practitioners who have been trained in Trauma Risk Management (or TRiM, a model of traumatic stress management pioneered by the Royal Marines (8, 9).

Other matters

Although not primarily a medical responsibility it is useful for medical staff to know something about morale and unit cohesion as they are key factors in determining the mental health of troops on the battlefield not least because they may have to lend their own staff into battle. Grinker and Spiegel suggested four main elements to morale, namely faith in the leadership, faith in the common purpose, having an adequate balance of work and rest and faith in each other (10). At times all but the last may be lacking, especially in operational environments. It is well known that faith in each other is a key element which determines how personnel will perform in difficult conditions and medical staff should encourage units to do all they can to foster a mutually supportive environment before they deploy.

Another important issue in determining how people will perform in an operational environment is the service person's view on how their family will cope when they are away. General Normal Schwarzkopf (1992) Commander of coalition forces during the 1991 Gulf War is quoted as saying 'You can train your men as much as you want, but what

do you think will happen if there's a war and these boys run around with the thought that nobody cares for their family? No way will they fight as effectively or that I can assure you" (p.1). Thus it follows that a well functioning family welfare service will assist military recruitment to adopt the required operationally effective frame of mind.

Finally, it is worth considering how apparently routine medical matters may take on disproportionate importance in the minds of those due to shortly deploy to an operational area. Will I be wondering how one's back or knees will hold up at the next fitness test or concentration may impair effective functioning in areas where the afflicted person perceives their injury might affect their personal safety or indeed the safety of colleagues. Thus when a medical professional considers that a medical complaint will not prevent deployment they should be forceful in passing their opinion onto patients to reassure them that they will be able to carry out all that the mission requires them to.

Supporting Personnel in theatre

The principles of forward psychiatry remain the cornerstone upon which the mental health of the British Armed Forces is maintained and managed in an operational environment. Forward psychiatry refers to the principles of Proximity, Immediacy, Expectancy and Simplicity. These have been extant since World War I (WWI) and claims have been made that when used properly up to 80% of personnel who present with operationally related mental health disorders can be returned to effective duty (Jones and Wessely (2003)). have argued that such figures are over estimates (12). The US military use a modern version of forward psychiatry called combat stress control which utilises the same principles. Thus in the absence of any other proven model of in theatre mental health provision the UK military still uses the PIES principles in the varied casualty treatment regimes in force.

Proximity

The principle of proximity refers to the treatment of personnel in close near the front line. In WWII this was [illegible] the sounds of the guns although [illegible] with asymmetrical warfare [illegible] fluidly moving battlefield being the [illegible] modern combat operations it is often [illegible] know where the front lines is. However [illegible] people who are suffering with [illegible] symptoms of acute stress within the [illegible] colleagues [illegible] platoon or company) is a good [illegible] concept.

This means that [illegible] must [illegible] ensure that provision [illegible] such tasking of stressed personnel that does not involve removal [illegible] This maximizes the chance [illegible] will be able to return to operational [illegible] within a short period of time. The aim of any management is to keep someone working in an operationally significant but rehabilitative position. This might be for example, helping the company sergeant major with an administrative task or assisting in re-supply of ammunition. It is important that unit personnel who supervise stressed individuals do their utmost not to unduly stigmatise them. In some cases it may be necessary to remove the firing pin from a stressed persons personal weapon this is less stigmatising than removing the weapon completely but this should not be done without careful consideration of the tactical situation or without the agreement of the command.

Immediacy

This simply means that when someone appears to be suffering it is a good idea to do something about it sooner rather than later. This does not mean that the possibly affected individual should be removed from the source of stress unless they cannot function but instead it may be worthwhile making sure that that person is the next one to get a substantial rest or to go for food. Depending on the operational imperative a variety of simple stress relieving strategies can be put into place. However the immediacy principle merely suggests if someone thinks a unit member is suffering with a stress related problem then it is worth doing something about it sooner rather than later.

Expectancy

This is probably the [illegible] of managing battle el[illegible] in sense of confidence [illegible] the effects of exposure [illegible] feelings are normal co[illegible] I'm fed ill you can s[illegible] ndv dual will be [illegible] front nue to fult l the [illegible] cases the first [illegible] Jo so Ir n ed c n [illegible] gnost that r s [illegible] be able to [illegible] ley that they will need t [illegible] area from their u r [illegible] tu ll ng prophecy Do [illegible] yo will find them T [illegible] l asues of a success [illegible] r e should be told w [illegible] be able to confru r [illegible] a es and the operat [illegible] m ember that dealno v [illegible] als s best done by avoid [illegible] nts To y [illegible] al eacho [illegible] ormal sell soon

Simplicity

[illegible] on hortes th s [illegible] r s s tar w l pe so [illegible] p s s [illegible] ev uns [illegible] o l [illegible] arge such as [illegible] from the wors of [illegible] ng [illegible] and [illegible] lking to th r [illegible] s are likely to be effective T [illegible] e phrase "3 l ors and a c [illegible] three not ments and good night s [illegible] s be what they see as the r ost effe e battlefield st ess [illegible] on [illegible] T battlefield s no place [illegible] counsellors ood [illegible] enagement s the [illegible] te ventio [illegible] reduce stress [illegible] vels

Operational Mental Health provision

The allocat on of mental health personnel to the order of battle s the respons bility of [illegible] Permanent Joint Headquarters (PJHQ). It will assess the size of the force that is due to deploy and est mate the psycholog cal risks that the m ssion is likely to pose to deployed forces. This risk assessment process involves numerous factors including the nature of the threat le g s there l kely to be a chem cal or b olog cal weapon threat wh ch will increase the psycholog cal r sks) and the exper ence of having deployed forces to the same or s m lar [illegible] ea res or operat on. Although r s d fficul o [illegible] so th s equates to one psych atr st and [illegible] e o ve psych atr c nurses be ng deployed to s pport a Br gade. Once an operat o [illegible] me s stab l sed t s poss ble to prov de [illegible] ay m ntal health care with embedded t m unity Psych atr c Nurses (CPNs) w th [illegible] egular supervis o y v s ts from a consultant psych atr st (13)

Psych atr c personnel s primary responsibil ty is to keep the f ght ng force healthy and effect ve. Th s means they will expect to l aise with the cha n of com nd and unit med cal staff as regularly as poss b e. Where there s no poss b l ty of keep ng an affected nd v dual w th their unit they will endeavour to rehab l tate evacuated pe sonn rapidly in theatre rather than retu n g them to the UK. Th s means that units should be ready to rece ve back prev ously aff cted pe sonn Th s will mean that med cal staff will need to manage the command s expectat on that wh le personnel are evacuated for a str ss-related problem they will not return. Return to dut fRTU) should be regarded as the norm rather than the excep on for most stress-related probl ms that org nate in theatre. The majority of those cases seen during Op Tetc 1 were RTU d (13). Clearly though there will be some cases where RTU s just not feas ble and mental health professionals in theatre will be able to adv se med cal staff about such nd v duals.

Homecoming and the post operational period

There are numerous anecdotes about the homecom ng of the troops after the Falklands confl ct. Most suggest that the Royal Marines who returned on the troopship Canberra settled qu etly into their lives having worked out their battle res due while sail ng. On the

...ot...ward...ts suggest...e...a troopers who flew home did ...ve the opportunity to move on from the ...ev...y necessary combat focused m... ...h...t...s...n that they ceased to ...ve...s. ...e...e they ...ve...or we...e base...h...v...r...ffer...s...n ...d...s...ve evidence ...s...t...e...

...e curre...p...c...s...ch ...ide...r...ers...der what's necessa...v...fo...ts personnel. This section will attempt to explore some of the potential approaches that may be considered and point out possible roles for medical staff.

Homecoming briefs

A psychoeducational brief (FMed 1021) for personnel who are due to leave theatre is usual practice and was mandatory for troops who returned home after the 2003 War in Iraq (Operation TELIC). This usually covers much the same as the pre-deployment brief emphasizing that some personnel may experience unusual and intense reactions to what they have experienced in theatre and that in most cases this will settle with time. Providing advice on the nature of the normal reactions to stress, effective self help techniques and sources of available support is routine. It is also worth providing troops with leaflets which restate the points bought out in the brief and which may be given to their families when they return.

Homecoming briefs also tend to cover the process of re-uniting with loved ones and friends. Letting personnel know that families may not have missed them whilst they are away or may not be necessarily as joyful as the returning troops would like is customary. Many soldiers, especially those who have not deployed before, expect their partners to have cold champagne on ice to celebrate and do not realise that those who have remained at home may instead be looking forward to being able to leave the kids with the service person and take the first opportunity they have had in ages to go out and have fun with their friends. Thus homecoming briefs are about stress education but also about managing expectation.

Debriefing [illegible]

[illegible] of decompression so [illegible] about in Canadian forces after deploying to Afghanistan in 2002. Instead of flying straight home they were instead sent to Guam for a week long period of intense stress education including anger management, suicide awareness and a busy daily work routine. They did not find any conclusive benefits and many personnel complained about the two hour long lectures, physical exercise sessions that began at 6am and being kept away from their loved ones back in Canada.

Although the need for decompression is a commendable response by the military, there is evidence to suggest that most service personnel prefer to talk to peers who have been on the same deployment and their family about their operational experience (14). Having an opportunity to talk about their deployment experiences in a low stress environment should provide the most therapeutic environment for those who have just returned from operations to process their experiences. Social support that is perceived as being supportive has also been shown to be beneficial (15). This is likely to be available from friends and family. However during the POTL period all personnel should know where they can gain support should they require it. This is likely to be from the chain of command, medical services, chaplains, welfare services or mental health professionals depending on which resources are available locally.

The debriefing controversy

Until 2000 it was standard practice for stress debriefings to be carried out for military personnel who had been involved in traumatic events which clearly may have included those experienced on operations. However there has been a myriad of evidence which has shown that routine single session psychological

debilitating [illegible] fact be harmful [illegible] Surgeon General [illegible] on the psychological [illegible] Such guidance [illegible] currently [illegible] Excellence (NICE) [illegible] management of Post Traumatic Stress Disorder (PTSD) (18). It is worth pointing out at this point that PTSD is an uncommon outcome after traumatic events or operational deployments. For instance, after the 1991 Gulf War, less than 3% of deployed troops suffered with PTSD. Other forms of mental disorder including depression, adjustment disorders and substance misuse disorders are far more common (19) although the majority of troops who deploy do not suffer with any mental health disorder.

However, although it is clear that not all personnel will require any form of psychological intervention, some will inevitably develop psychological problems as a result of their operational service. It is worth all medical staff adopting a high index of suspicion, also called 'watchful waiting', in their approach to personnel who have returned from operations. Most people who will develop problems are likely to show signs within the first few months of having returned home, although recent data from the USA suggests that in US troops the prevalence of operationally associated mental health disorders continues to rise for the year following deployment. As yet there is no conclusive evidence to suggest this is true for UK forces but keeping a watchful wait and ensuring the chain of command do the same is likely to be good practice. Immediate line managers and peers are probably in the best position to spot personnel who have stress related problems. Welfare services may also pick up operationally related psychological problems, of which many manifest as relationship problems. Additionally, unit discipline staff should be aware that behavioural disturbance that is out of keeping with an individual's previous disciplinary record may be a sign that a service person is suffering with a mental health problem.

Trauma Risk Management (TRiM)

Within the Royal Marines and some Army units, including the Grenadier Guards, there are a number of Operational Medical personnel who have been trained in the identification and simple management of traumatic stress related disorders. These TRiM practitioners may be able to assist both the command and medical personnel in maintaining vigilance after troops return home. Furthermore, gaining assistance from TRiM practitioners may be seen as less stigmatising by personnel who have concerns that asking for help for stress related problems from medical or psychiatric staff will adversely affect their career.

Conclusions

This paper aimed to give medical staff an insight into the important issues related to operational mental health. It should be remembered that keeping a military unit psychologically healthy is an effective force multiplier. The provision of good mental health is primarily a chain of command responsibility but there will be numerous times when the command will look to medical staff to advise them. Most people who suffer with stress in relation to operational deployments will not go on to develop formal mental health disorders and there are numerous ways that medical staff can intervene at an early stage to prevent stress related problems progressing further. As with other areas of medical practice, when considering operational stress the maxim that prevention is better than cure holds true.

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General

Mental Health Referrals to the Falkland Islands British Military Mental Health Team, 1986-96

G L Michael, N T Fear, J Hacker Hughes

Abstract

Objectives – To examine the pattern of out patient mental health care referrals for military personnel deployed to the Falklands Islands 1986-96

Methods – Data from referral books of British Military Community Mental Health Nurses based in the Falkland Islands were abstracted, entered into an electronic database and analysed

Results – Over the period 1986-96, 538 Service personnel were referred to the mental health out patient facility on the Falkland Islands. The majority were male (96%) and junior ranks (81%). Approximately a third of patients were referred for reasons relating to alcohol (31%) and for over two thirds of patients no follow up was required (68%). Differences were observed by Service with the Army having more referrals due to alcohol than the other two Services, whilst the Navy had more deliberate self harm referrals and the RAF more referrals for anxiety.

Conclusions – The lack of information on the total population deployed to the Falkland Islands over this period limits the interpretation of the results.

Introduction

This paper gives a brief overview of the Falkland Islands, the culture of the operational tour, the facilities available and the composition of clients seen by the Military Psychiatric Service. The paper then examines the characteristics of the patients seen by the Military Psychiatric Service over an eleven year period.

The Falkland Islands lie 300 miles off the southern tip of South America. They consist of two main islands and 700 smaller ones covering an area of 6 280 square miles, about the size of Wales. They were first discovered by the English sailor Captain John Davis on 14 August 1592 after being driven off course by a storm. 1690 saw the first landings on the islands by Captain John Strong, the first explorer of the British Admiralty who named the stretch of water between the two main islands Falkland Sound after Lord Falkland. Visiting Breton soldiers later named the islands "The Malouines" after St Malo, the port they had sailed from in Brittany, Northern France. This name was later corrupted by the Argentinians into the Spanish form of the name – Los Malvinas.

In April 1982 an Argentinian force invaded the Falklands. After 74 days the Islands were liberated from their occupation by a British Military Task Force. Countless Argentine and 262 British lives were lost. The Falklands are still not free from threat from Argentine and a British military garrison remains on the islands at a state of readiness and is likely to remain there for the foreseeable future.

Deployments to the Falkland Islands came in a variety of shapes and sizes, either on the basis of individual replacement or full unit strength, for four, six or more months, married accompanied or unaccompanied. Those on

ndiv dual deployment who made up the majority on the slands were detached from social structures

The Falkland Islands had a recognised military mental health service for a number of years provided by the British Army Medical Services A civilian psychiatric service was established in December 1994 as a result of the perceived needs of the civilian population who had previously been catered for by the incumbent military service Based at the King Edward VII Memorial Hospital Port Stanley this service has operated island wide going into the smaller settlements as well as treating those who live in the capital

Within the British Community Military Mental Health Services latterly based at Mount Pleasant Airfield in the Falkland Islands client numbers were monitored between 1986 and 1996 and broken down into their respective diagnostic sub-groups These data were then returned to the Defence Services Psychiatric Centre (DSPC) where they were examined Analyses of these data are presented here

Methods and Data

Data recorded in referral books were abstracted and entered into Microsoft EXCEL by the authors Data were routinely collected on Service rank gender diagnosis and disposal over the time period studied Civilian personnel who were referred to the military facility have been excluded from these analyses (n=187) Diagnoses were grouped by the authors into six categories alcohol depressive episode anxiety disorder stress deliberate self-harm or other Categories were discussed and agreed with a medically qualified colleague Disposal was aggregated into four categories return to the UK no follow up required follow-up in theatre or unknown again on the advice of a military medical colleague

Data Analysis

Distribution of all variables were examined with frequency (n) and percentages (%) being reported Chi squared tests were performed to examine differences in the distribution of categorical variables Analyses were also repeated separately for those diagnosed with an alcohol problem males and by Service (those with an unknown Service were excluded) All analyses were conducted using the statistical software package STATA (version 9 0) Statistical significance has been deemed as $P<0.05$

Results

Over the time period 1986-96 538 UK Service personnel were referred to the mental health outpatient facility on the Falkland Islands (Figure 1) The number of referrals peaked in 1988 with 98 with the mean number of referrals by year being 48

Table 1 shows the demographic and diagnostic profile of these patients The majority were male (n=516 96%) and junior ranks (n=435 81%) Approximately a third of patients were referred for reasons relating to alcohol (n=166 31%) and for over two thirds of patients no follow up was required (n=367 68%)

Analyses were repeated for the largest diagnostic group alcohol problems These analyses showed that there was a higher proportion of alcohol problems within the Army (49%) than seen for the other diagnostic groups (37% chi squared=13 35 degrees of freedom=3 P=0 004) No other statistically significant differences were observed (data not shown)

Analyses were repeated for males only (the numbers of females was too small for meaningful investigation) these analyses showed no notable differences from those presented in Table 1 for males and females combined

Analyses were repeated by Service for those with a known Service) (Table 2) There were no statistically significant differences observed by rank (chi squared=11 01 degrees of freedom 6 P 0 089) or disposal (chi squared=9 12 degrees of freedom=6 P=0 167) However significant differences were observed for gender within the RAF having proportionally more females (chi squared=16 79 degrees of freedom=2 P<0 0001) than the other two Services Differences were also apparent by diagnosis

Table 1 Demographic and diagnostic details of referrals to the military outpatient facility Falkland Islands 1996-96

	n	%
Service		
Navy	96	12 3
Army	219	40 7
RAF	224	41 6
Unknown	29	5 4
Rank		
Junior	435	80 5
Senior	81	15 1
Officer	16	3 0
Unknown	6	1 1
Male	516	96 0
Diagnosis		
Alcohol related	166	30 9
Depressive episode[2]	102	
Anxiety disorde	111	20 6
Stress	107	19 9
Deliberate self harm	33	6 1
Other	167	31 0
Disposal		
Returned to the UK	142	26 4
No follow up required	367	68 2
Follow up in theatre	14	2 6
Unknown	15	2 8

[1] Total comes to greater than 538 due to individuals having multiple diagnoses
[2] Includes other psychiatric and non psychiatric conditions

Table 2 Demographic and diagnostic profile of referrals to the military outpatient facility Falkland Islands 1996-96 by Service

Rank	Navy (n=96)	Army (n=219)	RAF (n=224)
	Junior		
46 (83 7)	184 184 01	188 (83 9)	
Senior	16 (24 2)	26 (11 9)	28 (12 5
Officer	2 (3 0)	7 (3 2)	7 (3 1)
Unknown	2 (3 0)	2 (0 9)	1 (0 5)
Male	65 (98 5)	217 (99 1)	205 (91 5
Diagnosis1			
Alcohol-related	19 (28 8)	82 (37 4)	52 (23 2)
Depressive episode	11 (16 7	37 (16 9)	32 (14 3)
Anxiety disorde	8 (12 1)	34 (15 5)	69 (30 8)
Stress	8 (12 1)	45 (20 5)	49 (21 9
Deliberate self harm	10 (15 2)	13 (5 9)	8 (3 6)
Other2	22 (33 3)	66 (30 1)	76 (33 9)
Disposal			
Returned to the UK	26 (39 4)	50 (22 8)	56 (25 01
No follow-up required	38 (50 1)	156 (71 2)	154 (68 8)
Follow up in theatre		6 (2 7)	7 (3 1)
Unknown	1 (1 5)	7 (3 2)	7 (3 1)

[1] Total comes to greater than the number of individuals due to some individuals having multiple diagnoses including other psychiatric and non psychiatric conditions

with the Army having more referrals for alcohol problems (chi squared 10 72 degrees of freedom 2 P 0 005) the RAF more referrals for anxiety disorders (chi squared 19 33 degrees of freedom 2 P<0 0001) and Naval personnel experiencing a higher proportion of referrals due to deliberate self harm (chi squared 11 97 degrees of freedom 2 P 0 003) In addition although not statistically significant referrals for stress related issues were more common among both the Army and RAF than the Navy (Army chi squared 2 11 degrees of freedom 1 P 0 15 RAF chi squared 2 76 degrees of freedom 1 P 0 10)

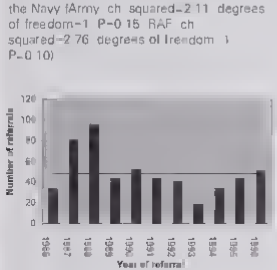

Figure 1 Referrals to the military mental health out patient facility on the Falkland Islands 1986 1997
The horizontal line represents the mean number of referrals across the time period studied

Discussion

Principal findings

Over the time period studied 1986 96 538 Service personnel were referred to the mental health out patient facility on the Falkland Islands The majority of referrals were male (96%) and junior ranks (81%) Approximately a third of patients were referred for reasons relating to alcohol (31%) and for over two thirds of patients no follow up was required (68%) Differences were observed by Service with the Army having more referrals due to alcohol than the other two Services whilst the Navy had more deliberate self harm referrals and the RAF more referrals for anxiety

Previous research

As far as the authors are aware no other studies have been conducted among the military population deployed to the Falkland Islands However studies have been conducted among those admitted to the military psychiatric hospital in Catterick(2) This hospital saw roughly 260 Army personnel per year substantially more than the number of clients seen on the Falkland Islands(3) The study by Neal et al(2) showed that of Army personnel admitted to Catterick (1996 1998) 26% were for alcohol or drug misuse and a further 13% had a depressive episode The proportions referred for these disorders among Army personnel on the Falkland Islands were 37% and 17% respectively

Advantages and Limitations

This paper reports the first examination that has occurred of these data which provide information on reasonably large numbers of personnel from all three Services

That said there is unfortunately a lack of denominator data for this population and it is therefore not possible to calculate rates Furthermore data collection was non standard sed (and inconsistent) with reliance on a brief description of the clinical condition being used by the authors to allocate diagnosis

Conclusion

No other studies have been conducted among military personnel deployed to the Falkland Islands Although some of the information is incomplete (possibly due to CMHNs following different procedures) the information is sufficiently detailed to allow some useful analysis of the data available However the lack of information on the total population deployed to the Falkland Islands over this period limits the interpretation of the results

Acknowledgments

We would like to thank Surgeon Commander

Nic l Greenberg for his help with the categorisation of diagnostic and d[illegible] al information

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Declaration of interest

[illegible] was employed by the UK Defence Medical Services. [illegible] was employed by King's College London

General

VELA Deployment 2006

L Hazard

VELA 2006 deployed with an Amphibious Task Group (ATG) on the 11 Sep 06. It was designed to demonstrate the UK's ability to conduct coastal and beach operations in challenging equatorial Sub Saharan and jungle environments whilst sending a strong message that the Royal Navy was there to support Global Counter Terrorism and contribute to enduring Maritime Security Operation activity.

The deployment consisted of two phases. The first Exercise Grey Cormorant took place in the UK off the South West coast and incorporated integrated Royal Marines boat and air training. Combat Enhancement Training/Force Integration Training (CET/FIT) Advance Force Operations and Amphibious Raids and culminated in an amphibious assault. The weather off the coast oscillated from hot summer to freak downpours and planned evolutions off the North Devon and Cornish coastline had to be cancelled as the weather grounded air assets and the 4.6m swell on the beaches meant that landing craft were unable to operate.

After a short operational stand down (OSD) in Gran Canaria and Gibraltar the ATG sailed to Sierra Leone, West Africa to conduct Exercise Green Eagle. This included jungle training activity [illegible] Amphibious [illegible] in 2001 and [illegible] OCEAN, HMS St [illegible] RFA WAVE KNIGHT [illegible] BEDIVERE, RFA FORT [illegible] ENTERPRISE and RFA [illegible] USS ELROD together [illegible] Commando Group consisted [illegible] Commando, 59 Commando [illegible] Engineering Squadron, 29 [illegible] Artillery, 539 Assault Squadron [illegible] Commando Logistics Regiment [illegible] Commando Royal Marines [illegible] Unit. In support of the Bde [illegible] Tailored Air Group (TAG) which consisting of Sea King [illegible] 846 Naval Air Squadron, [illegible] helicopters of 820 NAS, Lynx [illegible] 847 NAS and Chinook [illegible] Squadron Royal Air Force [illegible] approximately 3000 UK [illegible] the deployment which was [illegible] population at risk when [illegible] military strategy.

I received the warning [illegible] ATG the day I left to [illegible] world join HMS ALBION [illegible] three weeks after I got [illegible] prepare you with the skills [illegible] effective operator all [illegible] tactical training attached to [illegible] Commando Amphibious [illegible] battle within [illegible] enabled [illegible] by [illegible] Training [illegible] Tactical [illegible]

[illegible]

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he former incorporating a dental team whilst the latter was initially home to the Role 2 Surgical Support Team augmented with a consultant physician and the physiotherapist To complete the medical footprint 40 Commando Royal Marines deployed with the Regimental Aid Post (RAP) a GDMO medics and dental team who were to be put ashore to provide Role 1 medical cover to the Landing Forces (LF)

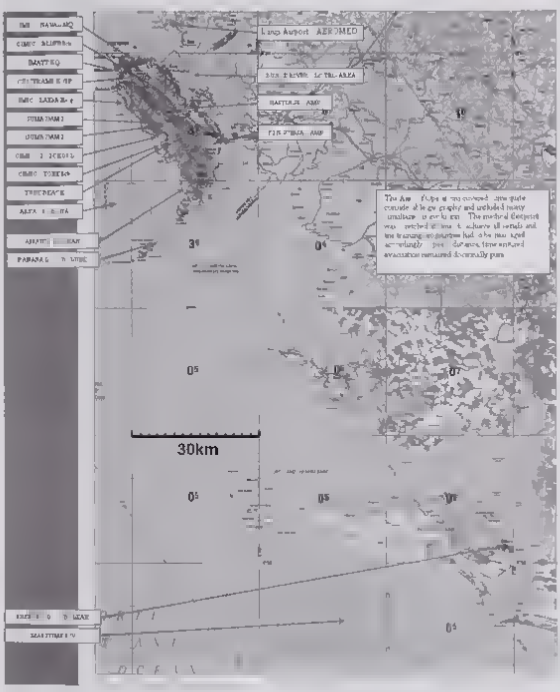
The main deliverables placed on the COMATG Med Ops component by Fleet were to declare the Role 2 Surgical Facility fully capable by 21 Sep 06 and run the Medical Mission which was

To contribute to the sustainment of the physical and morale components of the Amphibious Task Group by the timely treatment and evacuation of the sick and injured and the prevention of disease thus allowing freedom of manoeuvre with minimal manpower attrition in delivering the Commanders Mission Intent

Notwithstanding the complexities of operating with an amphibious task group VELA dictated that the high intensity training package would be conducted in isolated areas of West Africa around the Sierra Leone Freetown peninsular The was compounded by the lack of host nation medical support The best local hospital was assessed by our R2 Team as at best Role 1 with occasional Role 2 capability All these factors demanded the medical plan to be flexibly mobile but robust medical section of manoeuvre with the ability to assess triage sieve) treat and evacuate patients from a Population At Risk (PAR) of up to 3000 people with specific timelines

There was no illusion that the VELA ATG was highly suitable for CCP TCV Contingency Planning and in anst from Exercise Grey Cormorant detailed planning was developed to offer potential assistance to NEO (Non Combatant Evacuation Operations) and MSO activity This planning came to fruition at the end of the deployment when HMS OCEAN was re rasked on NEO standby

The medical plan was simple a standard linear evacuation from point of wounding


30km

(POW) rh cout [illegible] to Role 2 es req [illegible] evacr ar on [illegible] Obser ve Ma ge uv e [illegible] Jur gly Se a k ng Hr L opt [illegible] or one of rhe va au [illegible] Landing C aft Vet le E/F [illegible] Shore Ra d ng Cnt t ORC [illegible] (RRC) or even rhe La [illegible] It became apparent as t [illegible] shore l me of Sr erra Leo [illegible] sp ntered to their var ous d [illegible] rhar the Med cal Foo pr r [illegible] th n In essence rhe e wer [illegible] med cal assets to cove [illegible] Be ouema Guma Den [illegible] the ve ous L ttora [illegible] ser ons from the sea T s [illegible] ce cel over ror rhe do e [illegible] M C [illegible] M l tary Co operat on l tasks [illegible] & [illegible] ad ac v r es for su f oo s [illegible] t s ru g re Mep l shu v [illegible] o n on

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[illegible]

g ound support m both the north and south of rl e Freetown pen nsu er This work ed well and r the phys c an was needed then ground [illegible] erv y n rhar area would stop and he cor d [illegible] extrected ro where requ red This allowed the phys c an to ga n an apprec arion of the types of trop ca d seases endomic to rhe area and be avarlable m case of a no fly s tuat on

With the CONOPS n place the casualt es started to flow through the system and t was soon real sed that communicatrons were go ng to be a real threat to the evacuatron procedure Th s was not just a med cal concern as Command was struggling to co-ordmate movement on the ground w rh ther ab l ty to ro supply the basrc needs nclud ng Bread & Bullets We ref ned the commun cat on p ocedures to ensure a 24-7 over-watch from the Operat ons Room w th the new

Bowman commun cat on system backed by the Ships VHF Mobile phones were avalable as e fesr resort elrhough tlre Sierra Leone mob le phone network went down whilst we [illegible] ve e n rnearre Dur ng Exorc se Green Eagle all c asualt es were evacuated through rhe casualty cham and seen by a med cal officer accord ng to the 1 2-4 hour pr nc ple In one rnstance a Mar ne was b tten over 5 t mes on the neck chest and arm by a sp der he was evacuated from pr mary jungle to Role 2 medical care w th n 38 mnutes wh ch included the collectron of the phys cran The CHF (Commando Hel copter Force) pilots with the Green Lynx pulled out all the stops to get a rborne m 13 m nutes and broke several records n each ev ng the speed d stance and t me n putting down on a landmg s te ther was only very slightly b gger than the a rcraft itself and surrounded by huge trees

An mporrant part of the VELA deployment was CIMIC act v ty Th s s not only a great opportunrty for defence d plomacy (fly ng the flag) but for the Royal Navy to put someth ng m ro local communrties It also provided an opportunrty for Ships Compan es to ger ashore and see a b t of the country Around rhat t me r e UN WHO (Unrted Nat ons Worrd Health Organ sat on) declared an outbreak of Chole a r the east of Freetown argger than the K ssy I strrct Hav ng e xper ence m the regon rhey

appreciated that the outbreak wa[illegible] occurrence, albeit with larger cas[illegible] than previous years, with around [illegible] cases and 77 deaths in the [illegible] alone. We were fortunate to be far enough away not to have to cancel the CIMIC taskings [illegible] advice to the deploying teams

[illegible]

A [illegible] HQ [illegible] operat[illegible] with the R[illegible] local [illegible] understanding [illegible] in the [illegible] and especially [illegible] straight [illegible] comprehens[illegible] the fact [illegible] reassuring [illegible] HQ First HQ [illegible] CATF assu[illegible] this could be [illegible] coupled with the very capable surgical [illegible] who actually [illegible]. To the [illegible] they had [illegible] and achieve [illegible] move within [illegible] hours. They were able to receive patients with only minor delays. To coincide with this, the ATG was required to conduct a medical [illegible] and [illegible] shuffle and a [illegible] move [illegible] medical stores between ships, moving assets to [illegible] areas to mitigate the [illegible] training. It was then [illegible] that the medical log[illegible] were not quite [illegible] amphibious operatio[illegible]

[illegible] ability to [illegible] That said [illegible] and in othe[illegible] At [illegible] on MSO [illegible] or [illegible] Surgical [illegible] platform [illegible] Medical [illegible] about 70 [illegible] deficiencies [illegible] repatriation [illegible] to the LSH [illegible] Operations [illegible] people had [illegible] The [illegible] Nor Brit[illegible] 31 [illegible] ATG [illegible] this [illegible]

[illegible] To all patients [illegible] LA [illegible] Role 1 was 113 [illegible] 500 attendances [illegible] company medics [illegible] Sierra Leone.

[illegible] sailing from S[illegible] [illegible] Amphibious Task Group [illegible] [illegible] passage [illegible] [illegible] the UK [illegible] NATO [illegible] [illegible] that several [illegible] [illegible] reported [illegible] the [illegible] deployed personnel [illegible] [illegible] West African [illegible] were proving more [illegible] served as a reminder to all of the Task Group who undervalued the necessity of taking [illegible] anti-malarial prophylaxis. Although the side effects of Mefloquine (Lariam) can be quite harsh, it is the most effective prevention. In one instance of a suspected reaction to Lariam, a member of HMS ALBION developed [illegible] encephalopathy requiring CCAST (Critical Care Air Support Team) evacuation to the UK. However the rest of us [illegible] for insomnia and [illegible] very strange dreams!

[illegible] for me was an [illegible] experience whose [illegible] presentations clinically, doctrinally, militarily and administratively pushed me to the maximum. I have never been challenged so much in so many areas and have certainly been blooded in medical operations. The amphibious arena is a dynamic environment to work in and the ability to be flexible and reactive are essential qualities. The Post Deployment Report (PDR) filed with Fleet listed over 50 lessons identified, many of which were positive: RFA MOUNTS BAY as a capable Role 2 asset and the need for flexible and mobile modular kit for amphibious operations. The medical personnel of the RN, RM and RFA were credits to their [illegible] and Services with their ability to react and adapt to changing needs. This greatly [illegible] to the success of the deployment.

TOTAL PRESENTATION OF CONDITIONS DURING EX GREEN EAGLE

[illegible] Royal Navy [illegible] HMS ALBION [illegible]

J Royal Naval Medical Service 2007 93 1 23 26

General

Re-VELA-tion – A Report on the Role 2 / Medical Augmentee Deployment to OP VELA

D Whitehouse

About to deploy as physician to the Theatre Hospital in Basra, Iraq, last summer on OP TELIC I was asked if I would be interested in providing physician cover for OP VELA a major amphibious exercise later in the year when I returned. A brief conversation discussion with she who must be obeyed followed mainly revolving around the permissible family holiday thereafter in return for absence from paternal and other domestic responsibilities. Permission obtained I found myself flying to Gibraltar in late September to join HMS OCEAN en route for West Africa and OP VELA. I had thought there was little opportunity for naval physicians to go to sea these days other than PCRF [illegible] ARCUS and the prospect of sunshine was too good to miss.

The requirement for physicians to augment the surgical teams was predicated by the prevalence of medical threats to the area of operations and the deployment of personnel to austere locations for West African deployments with short notice lines of communication and no local medical facilities. At that time the only previous work [illegible] American Navy ships deployed to [illegible] Also given the 3000 nautical [illegible] RFA [illegible] [illegible]

Fig 1 HMS OCEAN off the Freetown [illegible]

phases of the exercise.

Assistance to Role 1 (R1) assets

It became evident during the passage south that further preparation of task force personnel was needed. We prepared and gave seminars on briefings and practical training on local health hazards and their prevention and treatment to embarked aircrewmarines artillery medics and first aiders. We were called upon to assist the R1 team in ensuring personnel going ashore were adequately immunized against prevalent diseases and in OCEAN on the passage to Sierra Leone assisted the ship's PMO and medics with R1 minor illness and injury. On the return passage in MOUNTS bay the surgeon and I were required to take sole charge of ship's MO for different legs of the passage in order to meet statutory requirements.

During the EX GREEN EAGLE jungle phase of LAND it appeared that 40 Cdo's organic medical assets would have been spread too thinly to provide comprehensive R1 cover on the two separate training locations. I was therefore tasked to provide an additional R1 capability from the logistic base at Harewood Camp. After a few days I was withdrawn away from the task group to play the RAP with men now had to be held in a field location to cover the LIVEX operations I saw during this activity. Table 1. During this time ashore I was recalled to the R2 facility for input to 2 urgent medical cases and to run the short notice TB close contact clinic discussed below and also accompanied a Priority 1 (P1) casevac with sprder to tas from the field in order to continue treatment at R2. Field training was halted during these absences.

Diagnostic Group	No
Soft Tissue Injury	51
Fractures	0
Dermatology	26
Upper Respiratory Illness	0
Diarrhoea & Vomiting	9
Mental Health Illness	1
Surgical Care	0
Gynaecological Health	1
Dental Cases	2
Casualty Presentation	2
Topical Disease / Insect Allergy	0
Ophthalmology	
ENT	13
Heat & Thermal Illness / Injury	5
Neurological	1
TOTAL CASES	127

Table 1. Diagnostic groups of cases seen at 40 Cdo R1 station.

Physician

My tasks as a specialist physician fell into three main areas: tropical disease routine secondary care cases and input to an ongoing tuberculosis outbreak on OCEAN. Although around 3000 personnel were deployed the incidence of tropical disease was low. Several patients presented with flu-like illness and malaria testing was performed to those. In one case during the exercise a possible positive was found and anti-malarial therapy given. Several other malaria cases were later diagnosed on several vessels after the task force had dispersed after the exercise. Other

serological testing for prevalent viral disease was not possible. There were several cases of [illegible] from various arthropods, often with secondary bacterial infection. The P1 casevac with multiple spider bites [illegible] above responded well to chlorphenramine for long swelling [illegible] the neck to prevent airway compromise. Only one of the tropical disease cases during the exercise required medevac for further investigation.

Routine secondary care referrals [illegible] two cases of chest pain, one possible angina, one possible pericarditis, one [illegible] symptomatic bradycardia (possibly mefloquine related) and symptomatic tachyarrhythmia, and a case of possible anaphylaxis. Only one of these cases required medevac.

Coincidentally HMS OCEAN had recently had an outbreak of tuberculosis [illegible]. During deployment there were several [illegible] to address and an ongoing [illegible] among the ship's company and embarked forces. A follow-up clinic for 8 [illegible] of the company was performed [illegible] route to W Africa. One of those [illegible] to have positive mycobacterial culture of a sputum sample sent from the clinic. As a result a further case-finding clinic was held onboard off Sierra Leone for close contacts of the case, with 5 personnel requiring repatriation for full investigation. Briefs [illegible] command were prepared and given on the developments. A full description of the TB outbreak is in preparation.

Surgical team

Of course, the surgical team [illegible] idle during the deployment. A list of [illegible] operations undertaken is at Table 2 [illegible] that besides several emergency [illegible] much elective day case surgery was performed. This was undertaken on an opportunity basis within the availability windows and the team was always available for general surgical emergencies in addition to the exercise-generated workload.

In general it was felt that the team had good facilities and that these were appropriately used. Besides serving to keep [illegible] and anaesthetists bar bills down to a reasonable level, the activity was of [illegible] pa[illegible] units, the military [illegible] and [illegible] It even allowed me as [illegible] having [illegible] skills [illegible] to assist in the

[illegible]

Table [illegible] OP VELA

[illegible] HMS OCEAN [illegible] 40 [illegible] RM [illegible]

MOUNTS BAY [illegible]

as outlined above. [illegible] MO ashore [illegible].

Once again [illegible] medicine to operate [illegible] provide more [illegible] possible [illegible] preventive measures [illegible] incidence of [illegible] although some risk behaviour [illegible] have contributed [illegible] casualties, particularly [illegible] medical intelligence [illegible] particularly helpful.

Overall, this was a challenging deployment [illegible] ways we [illegible] employed in our specialist roles, but [illegible] that we could be doing more and help [illegible] machines operate [illegible] the fact that [illegible] and computed [illegible] theatre [illegible] cases. Only 13 [illegible] medevac to the UK from R2 [illegible] included the 5 associated with the TB [illegible]. Most of the others were [illegible] musculoskeletal problems. Of note, the [illegible] only cases all remained in theatre [illegible] from the US Navy. The [illegible] team also managed to promote [illegible] by cutting waits for elective surgery [illegible] home by undertaking many such operations [illegible] during quiet periods in the exercise [illegible] consideration should be made to including such augmented secondary care teams [illegible] only on all major exercises and deployments. This may help improve [illegible] element of motivated specialists as well as more efficient care of personnel overseas.

The input of data, comments and photographs by Surgeon Commanders A Lambert and R Haddon, Royal Navy, is gratefully acknowledged.

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Surgeon Commander [illegible], Royal Naval, MB ChB, MSc, MRCP, AFOM, DCH, DTM&H, Consultant Respiratory Physician [illegible]

J Royal Naval Medical Service 2007; 93(1): 27-32

Historical

William Balfour Baikie and the Prevention of Malaria

W McConnaha

Introduction

On my first trip to Nigeria I had a chance to take my party from Lagos in the West to Aba in the East. We were helping to establish a school to serve Igbo children and we were working at the request of a Nigerian doctor to whom was a friend from Chicago. It was July the rainy season. The highway out of Lagos quickly evolved into buckled slabs of paving interspersed with huge potholes. The trip was long and the travel was slow. The driver had to steer the car from one side of the road to the other to move forward even a few feet. Meanwhile a steady stream of locals walking beside us was making much better progress on foot. We crept forward a Yoruba driver an Igbo doctor and three white Americans inching across the entire width of Nigeria.

A white person traveling in Nigeria is still enough of an anomaly that he or she will draw attention. People would notice me or one of the other teachers give a classic double take and then sing out the familiar salutation. Occasionally the greeting was in English. Usually it was delivered in the local language. But although the greetings were very different they were all saying the same thing—"Hello white man!"

As we were crossing the Niger River between Benin City and Onitsha a young man shouted what sounded like "Hello Bay Kay". It was explained that Baikie was the name of an early explorer of the Niger River who had been well thought of by the people of the region. As a result white men who had followed him were collectively called "Bekes". Writing on the occasion of the centenary marking the explorer's death Ernest Marwick (1965) noted that not only did some of the Igbo and Nupe use the word "Beke" to mean white man but the custom was more extended use of the name. A younger cleric was called "Iwa Beke" and the Englishman's country (England) was called "Ilen Beke". Marwick opens his article by saying:

"Although thousands of white men have come and gone and Nigeria has been since 1960 an independent nation there are people still in the little towns along the Niger as well as in places of power and responsibility in that large and interesting country who remember with cordiality the name of William Balfour Baikie."

His brief research led to the discovery that Baikie was a noted naturalist linguist and pioneer in proving that quinine was an advance of any malarial symptoms and of even the contraction of the disease. It seemed to me to be one of the most [illegible] men of African exploration yet to [illegible] of these West African discoveries, fully [illegible] on his behalf. All. How could someone whose [illegible] findings opened up the continent to explorers and trade have become at best a footnote to history. The question has taken me to Nigeria many times. But it has also taken me to London, Edinburgh, Aberdeen and the Orkney Islands. Using dispatches from Nigeria to the Foreign Office, reports made to the Royal Geographical Society, works of other Nigeria explorers, correspondence and personal discussions with contemporary African historians, family histories, local accounts and, most importantly, Baikie's own words, I have attempted to answer this question.

William Balfour Baikie

William's family was known as the Balfours of Tankerness and hailed from the Orkney Islands. Tankerness House is distinctive in the street from St. Magnus Cathedral in Kirkwall and originally served as the Cathedral's rectory. At the time of the reformation with church lands being confiscated and sold at auction, the Archdeacon managed to secure the building as his private dwelling. When he died, the house passed to his heirs who became entrapped for money. In 1633, they borrowed three hundred pounds from James Baikie of Tankerness to make payment. The property passed to James. Thus, the Rectory Mansion became Tankerness House, the Baikie family home.

Four generations later, in 1787, John Baikie was born at Kirkwall. He entered the Royal Navy in 1800 at the age of thirteen. By 1809, he was appointed to the rank of Captain. In 1807, after serving on five ships, he was promoted to that of Lieutenant-Commander. John Baikie commanded the Royal Naval flagships for Admirals Russell and Ferrier and saw a great deal of action during the Napoleonic War. Men of the Orkney Islands made their living from the sea. There were many skippers in the Orkney Islands, the designation given to any man who commanded a ship engaged in trade. There were only two men in the Islands who could claim the title of Captain. It was reserved for those who had commanded a ship in battle. John left the sea in 1814 but he would be referred to as Captain Baikie for the remainder of his seventy five years.

Captain Baikie remained single for many years but eventually married Isabella Hutton in 1822, when he was aged thirty five and she was twenty four. It was into this family of landed gentry with a proud naval tradition that William Balfour Baikie was born on 27 August 1825. His early education consisted of enrollment at the grammar school in Kirkwall, followed by a private school also attended by his brother, a host of male Balfour cousins and the sons of some of the more prominent members of the Kirkwall

[illegible] study [illegible] the University of Edinburgh [illegible] ersity Baikie studied under [illegible] ors, resident of Kirkwall, T S Traill. Professor Traill was a native of the Orkney Islands and a noted naturalist of his day. It was under his guidance that Baikie refined an interest in natural history and zoology. In 1847, at twenty two years of age, Baikie wrote A List of Books and Manuscripts Relating to Orkney and Zetland. In 1848, during his first year in the Royal Navy, he wrote History of Naturalis Orcadensis: Zoology, Part I: Mammalia and Birds Observed in the Orkney Islands, with Robert Heddle as his co-author.

At university, Baikie also worked under the direction of Professor Christison, who made him Clinical Clerk at the Royal Infirmary. This advanced medical training was a unique opportunity offered to only one resident each year. It attests to Baikie's aptitude for medicine as well as natural history. Upon taking his degree in 1847, Baikie entered the Royal Navy as an assistant surgeon. Baikie served on her majesty's ships Volage

Vanguard, Ceylon, Medusa and Hibernia in the Mediterranean between 1848 and 1851. In 1851 his next assignment was as assistant surgeon at the Royal Hospital Haslar.

Elevated to Command

In 1854, Macgregor Laird, with the blessing of the government, formed and financed an expedition for the purpose of establishing [illegible] the Niger River. Like Baikie, Laird [illegible]. His father had founded the [illegible] firm of shipbuilders and [illegible] had assumed the leadership from [illegible] in 18[illegible]. Laird and Thomas Stirling [illegible] the African Steamship Company for the commercial development of the Niger [illegible] and spent the next twenty years [illegible] a huge fortune through his trade with [illegible] and had designed the Pleiad, a flat [illegible] steamer specifically for this voyage.

Laird knew the Niger region, and he knew the [illegible] trade, but the government [illegible] the mission was to [illegible] and charting of the rivers. The [illegible] Geographical Society, a second sponsor of the expedition, was interested in exploration and [illegible] of new species of plants and animals. To assure the continued cooperation [illegible] of these two entities, Laird [illegible] in securing naval [illegible] to command the mission and [illegible] that the Society's [illegible]. One [illegible] he turned to was Sir Roderick Murchison, President of the Royal Geographical Society. Murchison knew of Baikie's work as a budding naturalist and made [illegible] to the Chief Physician at Haslar, S[illegible] Richardson, that Baikie be granted leave from his medical duties to accompany the [illegible]. Richardson, in turn, was a personal friend of [illegible] Baikie's father, who supported [illegible] participation in the mission. Thus, at the age of twenty-seven, Dr. Baikie had been [illegible] to serve as assistant surgeon and naturalist [illegible] proposed expedition.

[illegible] Beecroft, English Consul at Fernando Po, a veteran of [illegible] years of African exploration, was to have overall command. Lieutenant [illegible] of the Royal Navy was to [illegible]

command of [illegible] officer Dr. J. W. D. [illegible] chief surgeon [illegible] supervisor. The [illegible] with Baikie [illegible] regular gov[illegible] would spend [illegible] sailing from P[illegible] Lieutenant Ma[illegible] the outbreak [illegible] Beecroft died [illegible] from Porto [illegible]

Upon [illegible] was [illegible] found [illegible] had been selected [illegible] he could [illegible] assistant [illegible] the post [illegible] way about [illegible] decided [illegible]

Conquering Malaria

The Ad[illegible] [illegible] Baikie [illegible] [illegible] England in [illegible] exploring [illegible] from Timbuktu [illegible] [illegible] and the [illegible] natives were no [illegible] B[illegible] the Binue River [illegible] [illegible] voyage [illegible] all others. [illegible]

your charge and [illegible] your (Beecroft) [illegible] this mode of [illegible] vers and sho [illegible] but and assu [illegible] pro to remember that [illegible] the severe [illegible] the care [illegible]

Baikie's duty [illegible] Europeans [illegible] the early [illegible] medical historian had written: "The West Africa coast is equipped with a full range of unpleasant diseases from sleeping sickness through Guinea worm, bilharzias, yaws and dysentery, but the principal killers are two: malaria and yellow fever." This charge to above all protect the health of those entrusted to his care would allow Baikie to test his theory on preventing or lessening the impact of malarial fever.

It was generally agreed that something present in the swamp mists caused these [illegible] es and those who had studied this issue had formulated several theories. A London [illegible] had theorised at the time that the cause of death among the Europeans on the [illegible] Niger exploration had to do with their [illegible] habits and use of soap and water:

[illegible] state that one of the conclusions at [illegible] arrived as the result of some very [illegible] enquiries into the nature of fever [illegible] we call malaria makes its [illegible] not upon the lungs but [illegible] surface of the body. It was [illegible] led me to entertain the idea [illegible] of defending the skin from [illegible] by means of some [illegible] or of alone. There is a [illegible] circumstance that the most [illegible] in the personal [illegible] of Africa as contrasted [illegible] strangers who visit them is [illegible] of the one people is [illegible] face of their body [illegible] or the contrary with the aid of soap are at great pains to remove everything of the kind which even the natural secretion of the skin provides. Here then is a broad distinction between the personal habits of the two people—the one anoints the other washes. They are both equally exposed to the influence of malaria—the one escapes, the other is annihilated. I would only add that I think it important that it should be [illegible] in the evening as well as in the [illegible] because it would appear that the influence of malaria is most powerful between the hours of sunset and sunrise.

Those who had studied malaria had determined that it was caused in some way by the swampy conditions and had even correctly guessed that the fever entered through the skin. However, it would be years before others would determine that it was the mosquitoes rising from these swamps that carried the "noxious impression" onto the skin.

A second debate dealt with how best to treat the fever once it had been contracted. South American natives had learned that boiling tree bark and using the resulting crystalline alkaloid could effectively treat fevers. Spanish Jesuit missionaries in South America learned of the medicinal bark from indigenous Indian tribes. The Countess of Chinchón, wife of the Viceroy of Peru, was cured of her fever using this bark. The tree was renamed Cinchona after the countess and the resulting alkaloid was called quinine.

The use of the cinchona tree bark as a treatment had been discovered by English crews when slave ships had started traveling regularly between Africa and South America. Quinine had been used regularly in treating sailors who had contracted the disease. However, its use had been limited because the general medical establishment had felt it better to rely on the usual methods of treatment—blood letting and purgatives. A leading physician had written in 1850:

The mortality of Europeans on the coast is reckoned at anything up to 700 per thousand per annum. The poisonous

exhalations causing malaria can be found arising in the morning mists from the humid jungle over swamps of the delta smelling of death and putrefaction. Blood letting and early treatments seem to have the greatest impact on the disease. Fifty ounces or blood at the onset of the illness or fifty grains of calomel a day to purge and dehydrate is the normal medical practice

However Baikie had also studied the writings of naval surgeon Alexander Bryson. In 1847 Bryson presented to the Admiralty the Report on the Climate and Principal Diseases of the African Station in which he was able to announce that through the use of quinine to treat malaria the annual mortality rate had been halved. Bryson blamed the medical schools for neglecting this mode of treatment in favor of the traditional blood letting and purgatives. With some brusqueness he indicated that his fellow naval surgeons knew more about conditions in the tropics than all the academicians in London. He added

Cinchona bark and the sulphate of quinine are both extremely useful agents for the treatment of fever, and although their administration is apprehended but indifferently understood, still the numerous instances on record in which they have been successfully employed leave no doubt that their more general use upon the occasions most urgently needed. It is firmly believed that although neither bark nor quinine has the power of preventing the germs of fever from lodging in the system, nevertheless they most decidedly have the power of preventing their development in pyrexial action

It was 7 July 1854 and the Pleiad was in the final stages of preparation for the voyage. Baikie's extensive study of medical practices in the treatment of malaria led him to conclude that the most effective remedy once the disease had been contracted was the use of sulphate of quinine. When taken with wine this medicine had proven to be a great success in treating those suffering from malarial fever. When fate gave Baikie command of [illegible] his theory [illegible] prevention [illegible] stained he [illegible] ordered that [illegible] be given [illegible] each morning [illegible] reputed [illegible] command [illegible] knew [illegible] professor [illegible] collect the [illegible] for its [illegible] could lose [illegible] him.

Conclusion

The Pleiad first traveled [illegible] 118 days it traveled [illegible] point where the Niger [illegible] meet and successfully [illegible] 250 miles farther than [illegible] it. Each morning and [illegible] Baikie distributed the quinine [illegible] afloat. As a result [illegible] Fernando Po—for [illegible] of African exploration—[illegible] even the seasoned [illegible].

Whether born to [illegible] leadership Baikie [illegible] succeeded in virtually [illegible] collection and categorization [illegible] unknown flora and fauna [illegible] among his fellow explorers [illegible] over fifty African [illegible] extensive translations [illegible] language. His [illegible] returned Landsman [illegible] and his work [illegible] abundantly [illegible] with the native [illegible] gain [illegible] African trade [illegible] Taubman Goldie [illegible]. However he had [illegible] with Dr Barth [illegible] safely on the [illegible] England before [illegible].

[illegible] could be [illegible] the interior of West Africa [illegible]

[illegible]

living among the Igbo and establishing a very successful trading center. He also continued his exploration of the region, gathering a collection of new species of plants and animals, cataloguing and translating various languages and negotiating treaties with local rulers on behalf of Lord and the English government. In ill health and concerned about his family, he asked to be given leave to return briefly to England. In 1864, while returning home, he contracted fever and died at Sierra Leone.

William Balfour Baikie was a naturalist, linguist and explorer. But most notably he was a medical pioneer. One could argue that Dr Baikie should be remembered in much the same way as Dr Walter Reed or Dr Jonas Salk is today. The proof that quinine is a preventative for malaria could be considered on a scientific par with the development of a prevention for yellow fever or polio, and it was accomplished fifty years ahead of Reed's work in Panama and a century ahead of Salk's work in the United States. Yet Reed and Salk are remembered; Baikie is not.

Perhaps Baikie suffered not from a lack of success but a cruel turn of fate. His work in Nigeria was clearly successful. When Baikie returned to England and made his report to the Royal Geographical Society, he had already been upstaged by Barth's return. The Society had been a sponsor of both missions and elected to award their Patron's Medal of 1856 to Barth "for his extensive explorations in Africa ... and his perilous journey." Baikie received no such recognition. But what if he had made contact with Heinrich Barth? Imagine the drama of Baikie approaching Barth in some jungle clearing, plucking him from harm's way and transporting him triumphantly back to England. "Dr Barth, I presume." The proven prevention of malaria would have been shown in the light of a true hero's discovery. If Baikie and Barth had met up as part of the voyage, the meeting would have predated Livingston's and Stanley's meeting by fifteen years, and Marwick (1965) speculates that perhaps William Balfour Baikie would have become a household name rather than Stanley.

[illegible] M Lomal? BAE MS EdSp PhD
Associate Professor School of Education University of Pittsburgh

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Service News

Surgeon Rear Admiral Philip I Raffaelli QHP BSc MSc MBChB MRCGP FFOM

Director General Medical Operational Capability (DG Med Op Cap) and Medical Director General (Naval) (MDG(N))

Surgeon Rear Admiral Raffaelli joined the Navy as a Medical Cadet in 1976. Graduating from [illegible]burgh University in 1979 he joined the [illegible]marine Service and was the MO for HMS [illegible]OWN (Stbd) in 1981-82. He commenced [illegible] training in General Practice at RNH [illegible] attaining Membership of the Royal [illegible] of General Practitioners in 1984 wh[illegible] MO at RM DEAL. He began training [illegible] Occupational Medicine as Deputy Squadron [illegible] Officer at the Clyde Submarine Base [illegible] took an MSc in Occupational [illegible] 1987, passing with distinction [illegible] awarded the Best Student [illegible] Faculty of Occupational Medicine [illegible] Senior Medical Officer (Sub[illegible]) [illegible] at INM he was awarded [illegible] [illegible]ship of the Faculty of Occupational Medicine and accredited as a Consultant [illegible] 1989. In 1990 he undertook the [illegible] Radiation Protection Course at RNC GREENWICH receiving the Herbert [illegible] Award and passed with distinction [illegible] [illegible] received the Errol Eldridge Award [illegible] research into submarine escape and [illegible]. He joined HMS NEPTUNE as [illegible] PMO [illegible] 1990 then was the Naval Medical Officer of Health (Portsmouth) before [illegible] as the Submarine Flotilla Medical Officer as an Acting Surgeon Captain [illegible] [illegible] attended the Joint Service Defence College in 1995 and was awarded the [illegible] Student prize. He then served in the [illegible] [illegible] DSIL) as Med OPS (NATO) be[illegible] transferring to Northwood as [illegible] [illegible] in April 1998 [illegible] SGD [illegible] SO1 (NATO). He was appointed Director of Health (Navy) in March 1995 [illegible]

[illegible] of Surgeon Re[illegible] Roberts CBE QHP [illegible] Surgeon Rea[illegible] [illegible] MBChB MRC[illegible] [illegible] Director Ge[illegible]

[illegible] Surgeon [illegible] [illegible] awarded [illegible] [illegible] Occupational M[illegible] [illegible] (Navy) [illegible] [illegible] May 200[illegible]

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Editors Note In ge al
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Surgeon Rear Admiral Parfaell writes

t s with the greates pleasure that I was
ointed as ADG(N) to date 2nd January 2006
ea the new challenges that take a little
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ha e the Head of the Service Surgeon Commodore
N a e and I are both committed
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Cdre Lord Lo[illegible] and Mrs Penny Jarvis and Surg Cdr Calum and Mrs Barbara McArthur [illegible] Rot[illegible] and Mr Philip McNeill Lovegrove RNR at a garden party to celebrate the visit to RNH GIBRALTAR. The visit was part of the programme set up by DMS [illegible] to celebrate Gibraltar's Tercentenary. This was a good opportunity for the visiting RN/RM BRIGANTAR team.

Surg Cdre Lionel Jarvis RN, Matron-in-Chief RNH Haslar, and Surg Cdr Robin McNeill RNR, joined Surg Cdr Rob McNeill [illegible] consultant colorectal surgeon RNH Haslar, in the new endoscopy facility which is due to open [illegible] which is due to open [illegible] DMS staff and for the Britannia.

The Ensign to be raised at the last RNH!

CPOMA Jamie Cook

On Monday 12 February 2007 a small piece of history was made at Royal Naval Hospital Gibraltar.

It was a mild Gibraltar morning and the RNH Gibraltar ships company were mustered for the enhanced colours ceremony which was held to celebrate the initial raising of the white ensign.

RNH has not flown the ensign as it is not commissioned as a Royal Navy establishment but is instead a Permanent Joint Operating Base. For reasons lost in the mists of time all Royal Naval Hospitals have always flown the union flag instead of the ensign.

For the vast majority of the many years RNH has been a loyal servant to the service people stationed in Gibraltar, RNH has finally been instructed to fly the white ensign. This is the final few months of RNH's great honour and effective operational duties which have been associated with RNH throughout its long and distinguished history.

The ceremony was attended by the Commander Chaplain Venerable Peter Scott OBE and was messed by civilian members of RNH. In the post colours reception Hospital Commander Surgeon Commander Martin Randle described the ceremony as a proud moment in his naval career.

RNH will continue to fly the white ensign until the end of its service later this year.

History of the White Ensign

The first recognisable White Ensign was in use during the 16th century consisting simply of a white flag with a small St George's Cross in the canton. In 1707 the St George's Cross was replaced with the Union Flag in recognition of the union with Scotland. The St George Cross was then introduced to the flag as a whole to make it more identifiable from a distance. The modern White Ensign therefore dates from 1707.

Throughout this earlier period the Royal Navy actually had three different coloured ensigns as well as the White Ensign there were the Red & Blue Ensigns. This was due to the rank structure employed at the time. Many in the Admiralty felt that the Royal Navy's use of these separate ensigns was outdated and confusing. In July 1864 it was decided that the White Ensign was the sole ensign of the Royal Navy.

Service News

Honours Awards and Citations

CBE

Surgeon Commodore N E Badcock CBE
Royal Navy Retd

ARRC

Lieutenant Commander A J Horton QARNNS

Queen's Honorary Physician

Surgeon Commodore J J W Sykes QHP DSc FRCP FFOM Royal Navy

Queen's Honorary Surgeon

Surgeon Commodore L J Jarvis QHS FRCR MB BS Royal Navy

Defence Professor

Surgeon Commander M J Midwinter Royal Navy
Defence Professor of Surgery

Defence Consultant Advisers

Surgeon Captain (D) R C Sanderson Royal Navy
Defence Consultant Adviser in Oral and Maxillofacial Surgery

Surgeon Commander M Whittaker Royal Navy
Defence Consultant Adviser in Pathology

Academic Achievements

Surgeon Commander R Shah Royal Navy
Passed ASCAB in Orthopaedics and Trauma on 29 November 2006

Surgeon Commander S Dickson Royal Navy
Passed ASCAB in General Internal Medicine (Infectious Disease) on 4 December 2006

Acting Surgeon Commander D Freshwater
Royal Navy
MD

Surgeon Commander K Haworth Royal Navy
Associate of the Fa[illegible]
Surgeon Lieutenant [illegible]
Royal Navy
Fellow of the Royal [illegible]

Surgeon Lieutenant C[illegible]
Royal Navy
Diploma of Fellowship [illegible]
Anaesthetists

Surgeon Lieutenant C[illegible]
Royal Navy
Masters Degree [illegible]
Distinction 13 Dec[illegible]

Lieutenant J A Alley [illegible]
Diploma in Errede[illegible]

Promotion

To Surgeon Commander
(D) N J Davenport Royal Navy

Transfer of Commissions

To CC wef 1 Feb 07
Medical Services
Lieutenant P H Burnett Royal Navy
Lieutenant L Hazard Royal Navy
Lt A D Pinney Royal Navy

To MC wef 1 Feb 07
Medical
Surgeon Lieutenant D A Gordon Royal [illegible]
Surgeon Lieutenant C R Hunte Royal [illegible]

Dental
Acting Surgeon Lieutenant Commander (D) P Wells Royal Navy

QARNNS
Lieutenant A L Blakeley
Lieutenant J L Cooper
Lieutenant N E Hungins
Lieutenant I C Kennedy

To FC w.r.t. [illegible]

QARNNS

A[illegible] D[illegible]
To MC w.r.t. [illegible]

[illegible] Royal Navy
[illegible] Royal Navy
[illegible] Dent[illegible]

[illegible] Lieutenant Commander [illegible] Royal Navy
[illegible] Commander J M Neary Royal Navy
[illegible]on Lieutenant Commander S M Phillips [illegible] Navy
[illegible] Commander R A Ramaswami [illegible] Navy
[illegible] Surgeon Commander R R Shah [illegible] Navy
[illegible] Lieutenant Commander E H Yates [illegible] Navy

Dental

[illegible] Lieutenant Commander (D) M [illegible] Royal Navy
[illegible] 1 May 07

[illegible]ander D J O'Connor Royal Navy
[illegible] Lieutenant Commander W A M Dow [illegible] Navy

Surgeon Lieutenant Commander A D Hacklyn Miller Royal Navy
Surgeon Lieutenant Commander F T Marshall Royal Navy
Surgeon Lieutenant Commander A M Nelstrop Royal Navy
Surgeon Lieutenant Commander S R Schofield Royal Navy

Dental

Surgeon Commander (D) P A Mcnall Royal Navy

QARNNS

Lieutenant Commander A L Holland
Lieutenant Commander J C Thain Smith

Placed on Retired or Emergency lists

Commander F Reed OBE Royal Navy
Surgeon Captain J Turner Royal Naval Reserve
Surgeon Commander N G Fisher Royal Navy
Surgeon Lieutenant Commander N S Maslaman Royal Navy
Surgeon Lieutenant Commander (D) W A Scott Royal Navy
Surgeon Lieutenant Commander D A Wilkinson Royal Naval Reserve

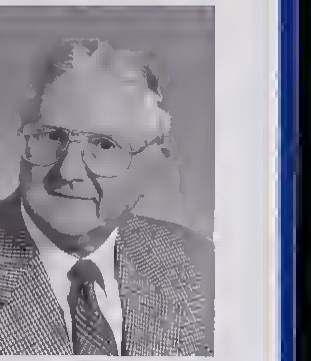
Obituary

Peter Gordon Harries MD FRCP FFOM MFCM DObst RCOG DIH

Pete Har es w o se ved es P esde t and Ho o y Se c e y o the Soc ety o Occ pat o a Medic e end wa ade a Ho o y Membe 2002 d ed pe ac e u y on 20t Se te be 2006 a 75 H bi thday o e as at o ostate ce ca e d ega d o s he was an ns ed ng sp at o e o upe a p yc at w c ea ned e ta al nc e o h o g a ese a c ev o ed c ow edge o asbestos e ated d seases Th s wo was the bas s o p ovemen s n wo k ng standa ds t at p ov ded t e sa s o p ec o o ou ess tho sa ds o wo ke s wo dw de

Bo n Bynaa a Ca a the she Pete wa p o d y ba o and ast es de his ute qu e demeano w en encou ag ng end ce eb at ng the at o a ugby a ball team H s une a se v ce was o a Welsh songs and a o y He was ed at Ogwe ton Gamma Sc oo Ells e e Co ege n Shopsh e and The London Hospital Med a Co ege where s ude es n dust e ned c ne was ns ed by the dynam sch a es anc ac and a Donald Hunte He p ayed ep esen a ugby football ew en s oote ay a squash ecquests and s e be ed as ode student He graduated MB BS n 9 s then following p e tegi a on appo n e t e West Suffolk General Hospital n J ne 1966 for his National Se v ce He e ed the Royal Navy on a 3 year Short Se v ce Co ss on the rank of Act ng Su geo Lieu enan and was immediately n ac to d ty n the Se ces

That August he jo ned the Da ing Class destroyer HMS Diam Along w h ese HMS Newfoundland they au d ed casualties Don t an Egyptian ss ps v severely dam aged by o c a ac e Newfoundland and then n shed off by t



a ay ng Da a v t was t o ght she s ay ng c am he ves t o ved n e o t s v o t e wreckage t e Lny s t e t ec e y m ee ng o t z sh e ounded Peters a t u e po ted that He was n ental ns a bet of ves end ad ap o de d cult n h o ess ona help and a d ade Th Company has ed t e ex Birthday L ve e ves awa ded the ego d ng ed d sp c es n t e ng sh and d st ngu shed s v ces to g oup s s n Nor Eas n ns v t ut ve have o a c a ce want ng t co e tests o h

in the rank of Surgeon Lieutenant and to the Royal Marine Depot Eastney. He served in the Infirmary as well as in the pattern for his professional colleagues recorded that he was very active. Work with him ren ains in the duty and tying up to the Hin was considered an excellent de for Dnat he gained the Diploma of the Royal College of Obstetricians & Gynecology having sat the exam- ner whether or not he could unfold books again.

He transferred to the Permanent Naval late 1963 with a view to specialising in Preventive and Industrial Health took up the post of Assistant Medical Officer in Devonport Dockyard in September 1964. He observed during his clinical duties that men who were occupationally exposed to asbestos but who did not come under the Regulations designed to provide protection and so went unprotected had signs of asbestosis. He further inspired and was encouraged in this endeavours by Geoffrey Shears a local clinical physician. Having studied in his own time and passed the Diploma in Industrial Health in July 1965. He so impressed his Examiners with his knowledge especially of asbestos related diseases and the conclusions he had drawn from his clinical observations that Professor Richard Schilling of London School of Hygiene sent for him after the exam- and suggested he should study for the MD on this subject. He also alerted the Medical Director General (Naval) of the undertaking research and that Peter was the man to undertake it.

That professorial intervention together with his serious very positive assessment of the situation once professional judgment and persuasive diplomacy finally made of purpose and high sense of duty resulted in usually swift action. By that date the MDG(N) had arranged for Peter to be appointed for special duties to establish in Devonport Dockyard a joint Ministry of Defence and Medical Research Council unit and initiate research into the asbestos problem and early detection of the disease

Capt [illegible] 1960.

On [illegible] 1962 for a two year Short Service [illegible] he was appointed

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work and achieved 84%
success was achieved principally
Peters meticulous planning
friendship and ability to
managers and the Senior Medical
these Yards (including David
Oliver and Jeff Nicholas
dedicated co workers He also
workers themselves and the Trade
officials who represented them
Convenors Shop Stewards and
became staunch allies

Peters reports and advice were
immense value to the Ministry of Defence
Managers of all the Royal Dockyards
studies confirmed the size of the
led to major improvements in working
practices in all the Dockyards and in
control of the removal of asbestos
of alternative materials Evidence of
already done with has enabled over
years since these changes took place

Dr Simon Hall OBE RCS (Eng) FFOM

Obituary

Surgeon Commodore F R Wilkes MBE OStJ QHS FRCS (Eng) Royal Navy

The attendance of so many colleagues at Roger Wilkes' funeral some fourteen years after completing Naval service was testimony to the respect and affection in which he was held. Sadly progressive and finally complete incapacity from Lewy body disease had blighted his retirement.

Born in Smethwick in 1934 he was educated at King Edward VI School in Stourbridge and qualified at Birmingham Medical School before joining the Royal Navy in 1959. His first appointment was to HMS ARK ROYAL in the Mediterranean and North America followed by two years as a junior Surgical trainee at RN Hospital Haslar. His sea career resumed in 1963 in the aircraft carrier HMS VICTORIOUS deployed to the Far East, Japan and East Africa. This commission was marked by his appointment as MBE for his innovative handling of a multiple fracture injury instructing the Ship's Company to enter to produce a wooden frame to hold the fallen who were freed, he himself saved the victim's life through all gently Pickwickian stature belying a surprisingly fleet of foot having been a rugby player in younger years and a good diving champion. During a night [illegible] New Entry Medical Officers [illegible] clear quickly to escape his capricious [illegible] action only to fall in darkness [illegible] and subsequently [illegible] found after one Lady [illegible] limped in blackened by [illegible] injury he made [illegible] ways into Portsmouth Football [illegible] Haslar days [illegible] Crabbe [illegible] gear chaos was averted by [illegible] plastic with [illegible] Royal Marine Orlit [illegible] the [illegible] plaster [illegible] [illegible] cock.

Roger became a fellow of the Royal College of Surgeons of England in 1965 whilst serving in Haslar. During the 1960s he served in the HMS EAGLE and ALBION through the Malaysian Confrontation. A relatively short but successful surgical interlude at the Royal Postgraduate Medical School in Hammersmith followed by a return to Haslar as Professional Surgical Tutor. In Portsmouth he [illegible] skills with [illegible] and [illegible] to [illegible] Medical Society of the 1970s. He was much liked by Admiral of the Fleet Sir Caspar John [illegible] bilateral leg [illegible] for the

calmly e[illegible] Surgeon Captain [illegible]

Whilst [illegible] personal [illegible] Medical Officer [illegible] the Falkland [illegible] admired [illegible] mind. A[illegible] be expected [illegible] was always [illegible] by those [illegible] observations [illegible] endeared [illegible] colleagues. Throughout his career [illegible]

[illegible]

[illegible] 18 November 2005.

Dr J Michael Beeley CBE FRCP

Notice has been received of the deaths of the following:

Surgeon Commander Sidney Hamilton Royal Navy
Surgeon Commander Iain MacGregor McIntyre Royal Navy

The editor would welcome any words in memory of them.

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Precautions are to be taken to t[illegible] confidentiality of patients n ex a[illegible] illustrations e g by masking ne[illegible] photographs Where a par enr u[illegible] might be dent f ed from an [illegible] from the text it s esser r al [illegible] permiss on s obtained f om tho [illegible] forwarded w th the man sc pt R[illegible] experiments on human sub ec s [illegible] cons dered unless the protoco [illegible] f van appropriate e hics co[illegible] followed and the ar thors state [illegible] f subject gave h s o fe r [illegible] consent A copy of the letter of [illegible] ed by the ethics com ttee [illegible] prov ded

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Editorial

In putting together this edition of the Journal I was struck by the [illegible] position to publish an article on smoking prevalence in a major [illegible] time as national legislation prohibits smoking in enclosed areas [illegible]. As we are aware, MOD policy has been introduced in advance of [illegible] interesting to repeat the survey in a few years time to ascertain [illegible] have taken place as a consequence of this legislation.

I occasionally follow the footsteps of one of my predecessors into [illegible] potential interest and whilst on the subject of smoking [illegible] short article entitled 'Education and the Cigarette' in which the [illegible] smokers into gastric, cardiac, respiratory and nervous types. The [illegible] described and advice given on how they might each moderate their [illegible] concluded that "we can stop a man's rum, we can stop his beer but [illegible] smoking is beyond us, therefore let us try to educate him to smoke [illegible] the interests of his health". Of course education remains an important factor but we have the added advantage of access to therapeutic agents to aid the smoker kick the habit. Legislation may help but education and therapeutic intervention will be required for some considerable time to come.

Despite the fact that it is the 25th Anniversary of the Falklands the Journal had not originally planned to mark the event. However the campaign was a watershed in the history of the Royal Naval Medical Service as it rose to the challenge of delivering healthcare so far from home. In a last minute change to mark the anniversary a number of individuals were invited to contribute their personal thoughts and memories on events in the South Atlantic; not all have responded in time but as no completion will ever be complete their omission does not diminish the purpose of the request, nor their contributions which I hope readers will find interesting. For me the poignancy of the anniversary was brought home in Gosport's Falklands Gardens where veterans gathered in company with Baroness Thatcher to remember the dead through a simple service and continue the tradition of families laying flowers on the memorial. I was the senior Naval representative present and was invited to take the Salute with the Mayor and Baroness Thatcher at the subsequent March Past.

Integral to the provision of healthcare to the Royal Navy in 1982 was the then RNH Haslar; how rapidly times and circumstances change as this edition of the Journal also records the military withdrawal from what became (again) the Royal Hospital Haslar bringing to an end 254 years of service as a military hospital. I had the privilege of being invited to attend the day which included a final service within St Luke's Church which itself concluded with a ritual locking of the door, also ending a similar number of years of spiritual support to patients, staff and the local community.

Healthcare for the military community, serving regulars and reservists as well as veterans, remains a subject of controversy with no obvious solution which addresses all

1 Coutie JTS. *Education and the Cigarette*. JRNMS 21:37-39. 1935.

the ssues togeth r. T ny bl ck of th ngs that need to change and a great deal of unrecog sed ... As we see after every study every chang n r ntr d th t e De ence Med cal Services every change n s ngle serv ce ... for good meet the resolut on of nter service d fferences and the object ves of th ... oes are rarely real sed because they nev tably do not have suffic ent me to be n or are left high and dry by external change in the med cal military or pol t cal w rld. I can t help think ng that we are chas ng the metaphor cal pot of gold at the end of the r nbow

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Falklands

Falklands 1982

A J Walker

Having been appointed to Captain F6 and spent much time with squadron ships at FOST the opportunity to deploy to the West Indies was most welcome. Little was I to know on a bleak mid March day in 1982 as HMS PLYMOUTH sailed under the Forth Bridges from Rosyth how different this was to be.

Spring Train 82 was a major Fleet exercise off Gibraltar – we were tenth ship into harbour – and far out on the mole. Rumours began to appear about 31 March that all might not be well in the far South Atlantic and when we sailed on 1 April we began to brush up on the Falkland Islands rapidly. Thankfully the Cdr ME had served with the British Antarctic Survey (BAS) and had a stide show on this area with him (it pays always to take a favourite lecture with you!) Suddenly our planned programme was disrupted and we were storing to head south to Ascension Island from the RFAs and ships heading north. Would a 21-year old Type 12 frigate be sent to the front line we wondered? Certainly the twin 4.5 inch gun was useful in NGS but more likely we thought we would be guard ship at Ascension or even a Fleet mail ship. At this stage there was a forlorn hope that diplomacy would prevail and we would get on with our intended Caribbean programme.

Wrong again! Having reached Ascension in the van of the main Fleet now starting to sail from UK we stored again and set off south on OP PARAQUAT – the recapture of South Georgia in company with HMS ANTRIM and RFA TIDESPRING. Aboard all began to get more serious. Lectures and exercises in NBCD damage control fire fighting and first aid were a daily occurrence. The ship lost its frivolity as ceremonial items were stowed below the wardroom became a secondary

[redacted] officers met to discuss medical strategy including the surgical team on RFA TIDESPRING and the Cdo MO attached arranged blood donor sessions to provide a Group O blood bank and agreed that TIDESPRING would be the surgical ship. Within a few days we sighted S Georgia icebergs and smaller growlers. After [redacted] insertions of SAS were thwarted by poor weather. Suddenly we were at action stations an Argentinean submarine was sighted on the surface attacked by the helicopter damaged and headed for shore. Then HMS PLYMOUTH opened fire as the supporting Cdo and SAS landings. Quite and then Leith captulared with only one major Argentinian casualty treated on HMS ANTRIM having lost a leg [redacted]

Battle had denied we headed back to the main Fleets air congregating for the eventual landing. The southern ocean had a long swell and the weather can be appalling but we had been at sea for some time and were used to defence watches and [redacted] in action so morale was high. The sinking of GENERAL BELGRANO and then HMS SHEFFIELD brought home to all [redacted] real tres of war and the vulnerability of the Task Force and the became subject [redacted] solemn and thoughts of prospective He [redacted] it was strangely exciting to be part of the [redacted] Fleet frigates destroyers and [redacted]

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m ng

By the beginn ng of June the a r war was
d m n sh ng Goose Green had been captured and rhe great yomp and tab across E Falkland was allow ng the Land Commander to prepare for the push on Stanley It was 8 t ne (better known as the day RFAs SIR GALAHAD and SIR TRISTAM were hit) that e were asked to f te on an Agent n ean OP Mr Rosal e W Falkland overlooking San Lar os No sooner had we edged out into the Sornd than a r craft bounced and bombed us Although no bombs exploded they set off e depth charge on the flight deck which caused a major fre aft and damaged the after n ortar handl ng room Cannon fire peppered the runnet turret and ships s de one round penetrat ng through the after heads and smok the sickbay As a major fire raged in rt e after PO s mess and the junior rates d n ng hall the sickbay was evacuated over r e upper deck The waitdroom became the h d med cal fac l ty and received 5 a t es the worst of wh ch had e j r e at ng tenrporat tobe injury from a p ece d dom metal Another was lucky to survive h v ng been overcome by smoke and found face down almost drown ng n surface water the deck T me seemed to move very slowly There was no fear as everybody had someth ng to do and just got on with t – tra n ng really does work The walking wounded refused much help preferr ng us to look after the major nju es and Buddy support did work It was only later having evacuated our casualties to Ajax Bay (Surg Cdr Rick Jolly appeared out of a helicopter to ass st) that we were able to take stock and realise how fortunate we had been and the ship although battered had power major weapon s systems and propulsion intact

Lck ng your wounds s catharc s per od w th Sitrep Seaspread allowed much needed repa rs to surv ve the S Atlant c weather but also allowed the ship s company to de-stress away from the ma n area of act on However by n e t d June we were back on the gun line ready to s pport the f nal push nto Stanley when we heard of the surrender

The return home was not delayed long as greator repairs were needed but m the warmer Equatorial cl mes there was an

opportunity for all to [illegible] and to paint ship. This [illegible] but I thought it helpful to a[illegible] some small part with [illegible] their ship. I am s[illegible] help [illegible] homecoming process.

Our return via Ascen[illegible]

R[illegible] to a [illegible]

Surgeon Captain A J Walker R[illegible] on Medical O[illegible] (JTH 1982)

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The Falklands

The Falklands War – A reflection from a newly qualified Medical Assistant 25 years on

D C Scarborough

The 2nd Apr f 1982 was an ordinary F day for n e Hav ng qualif ed as an MA in the Feb ary of 1982 my duties were on C6 ward RNH Hester In those days there was no Pa l y training L fe was good and for the t r n e y naval career f e m g and ex ms whe e not a major part of t Weekend eave r my home town beckoned When I j ed the RN m 1980 l ke many others t not have g ven the Falkland Islands a thought I certa nly would not have d on t be ng the first operat onal or menn in which I would serve Fo owing news of the mves on I remember the ous tl et the Surg cal Support Teams g t ustered but at this point did not f I would play a part Th s was very ch t y ew I expressed to my friends over c d when they questioned me as to t t F I would soon being depart ng to the a ands

y ery ur om weekend leave to a late M day 05 April 1982 I w tnessed the HMS tNVINCIBLE and HMS es dur ng the morning and early r day that t began to dawn on e e ved d ence rhat I might deploy g ea ue we e being deta led It f e a r was informed that I y e boe d the SS CANBERRA a ons I d d not join pl or to so hampron I flew along to Ascension Island to tBERRAs e vel On joining I R I en ber be ng swept up by y r preparat on of the e ng of the Mar nes Th was my f st tmo at t J l t expe enue r wes n e n ela st ft troop carr e The prepa at on of the t osp tal fac ty wes fasc nat ng dar nt ng and ex c ng Although I would never have edm tted t at the t n e a tt e b t scary It was a very d fferent fac ty to what we now see n rt e PCRF Angus but one th ar would ve y n uch prov de a serv ce An HDU wh ch had prev ously been an en erta n e t area wes be ng prepared underneath one of the make sh ft flight decks Entry nto the hosp tal facility was v a a ramp that had been built down from the flight deck nto a t rage area As you would expect we exercised the use of th s fac ty frequently between Ascension and the Falkland Islands At th s point d d I really bel eve we would see act on no probably not This v ew changed for me I ke I believe for many others with the sinking of the BELGRANO and HMS SHEFFIELD

For a newly qualified MA in th s type of env ronment looking back I would have expected that there would be self doubt about my ability and the role that I was required to perform However hav ng been swept up n the preparat on there was perhaps no t me for th s SS CANBERRAs hospital fac ty was very much involved in prov d ng med cal support to OPERATION CORPORATE It treated a total of 172 casualt es of wh ch 90 were Argent n an

Its most famous presence was probably wh st sat n the middle of San Carlos Bay (Bomb Alley) on 21st May 07 It had entered San Carlos Bay to off load its very valuable cargo of troops However t was left as what would now be cons dered a very vulnerable target None the less it prov ded treatment to a number of casualt es on that day from a number of sources which nc uded the stricken HMS ARDENT

A[illegible] the war SS CANBERRA was tasked [illegible] POWs back to Puerto Madryn [illegible]. This was a strange [illegible] SS CANBERRA was escorted [illegible] Puerto Madryn by a Type 42 named Sa[illegible] a Trinidad. We had Argentinean [illegible] stores to [illegible]. The pool and sonar [illegible] the [illegible] POWs received was [illegible] to that which the SS CANBERRA had [illegible] troops and crew received on its return to Southampton on Sunday 11 July 1982.

To receive exposure to that type of environment was an incredible experience so early [illegible] was coupled [illegible] terrible realities [illegible] of the [illegible] past and [illegible] people [illegible] I would [illegible] reflection [illegible] will be [illegible] the current [illegible] chance of an early deployment [illegible] an operational arena is I believe more apparent and likely than it was in 1982.

Lieutenant D C Scarborough Royal Navy

The Falklands

Memories of the Falklands Campaign in HMS HECLA

D G Bruce

On the Saturday in April 1982 when the Falklands Islands were invaded I was attending the BMA Junior Doctors Forum at Milton Keynes. Slightly saddened that I was not called away that weekend I returned to work in the Underseas Medicine Department at HMS Dolphin the following Monday eager to discover what the Appointer had in store for me. After a few days the letter arrived. I was to be appointed to a Type 21 Frigate. I called the ship directly and began to discuss the host of items necessary to prepare to sail in early May to the South Atlantic.

As a Senior Surgeon Lieutenant I had by 1982 over 4 years sea-going experience in HMS KENT been on a Joint Services Expedition to Nepal and worked in Devonport Dockyard. It seemed to me that the Frigate appointment was just right. With great excitement I planned lists of things to do equipment to take and uniform to pack. And then to my disappointment the appointment was cancelled. Instead I was to report to RAF Lyneham on Thursday 15 April 1982 to fly to Gibraltar to join a ship there. I was not told the name of the ship and was rather concerned that I might be consigned to the SS UGANDA being fitted as a hospital ship in Gibraltar at the time. With a mixture of relief and trepidation I discovered that I was to join HMS HECLA.

HMS HECLA was a Hydrographic Survey Ship under the command of Captain G L Hope Royal Navy. The senior of the Survey Ships HMS HECLA had been en route to Monaco to attend an international Hydrographic convention when she had been redirected South. Her role during Operational Corporate and that of the other Survey Ships was to act as a tender to the hospital ship SS UGANDA carrying stabilised casualties from the hospital ship to Montevideo in Uruguay from where they were to be evacuated home by air. HMS HECLA already had a Surgeon Lieutenant Martin Newman assisted by LMA Matt Prickett and the medical team was augmented by myself and 2 MAs. MA Chadhim and an MA from Newcastle known to one and all as George.

After a brief docking during which HMS HECLAs yellow funnel was painted white with red crosses added to the funnel and hull we stored fuelled and late April sailed south. The passage to the Falklands took about 3 weeks and during that period we planned and exercised for our new role. In order to practice having casualties arrive by air I was strapped to the underside of the Ships Wasp helicopter for a series of take off circuiting and landing manoeuvres a complex evolution I would not wish to repeat. During this period we also heard about the sinking of HMS SHEFFIELD. Suddenly the entire enterprise seemed more serious.

On arrival in the grey waters of the South Atlantic HMS HECLA was assigned to a read cross box an area of sea about 100 nautical miles by 50 some 100 miles north of the Falklands. Over the next 2 months this was where we were based leaving the box only to carry stabilised casualties from the SS UGANDA to Montevideo and stores and mail back the hospital ship. In the box we were safe from enemy action but steaming back and forward often in high seas was not much fun and turning across the seas in the middle of the night produced moments of terror. I recall one morning coming into breakfast rather sharp-faced not having slept at all to be much relieved to learn that nobody else had either

D[illegible] to the South A[illegible] to Montevideo The passage [illegible] about a week and [illegible] we carried a [illegible] as the crews of [illegible] vessels suspected [illegible] rendezvous with the [illegible] prisoners and [illegible] ships grey on the horizon This was the only time in the entire deployment that we saw the Fleet That first passage also enabled the ship to exercise the berthing arrangements for casualties They were put into the Junior Rates accommodation whilst the Junior Rates were relocated to hammocks in the ships hold In the cold conditions of the South Atlantic this was singularly unpleasant

Life at sea was not without its pleasures Well into June it was possible to buy cream eggs at the NAAFI and when they had gone I discovered that a small glass of Tia Maria had much the same effect Each Saturday we held a morning school in the sickbay and the Wardroom was well supplied with films albeit slightly aged If I ever see another Clint Eastwood movie however it will be too soon

On the second passage to Montevideo we carried some 40 or so Welsh Guardsmen who had been caught in the bombing of the RFA SIR GALAHAD They had been treated initially in the SS UGANDA before being transferred to us All had burns to their faces and hands HMS HECLAs medical team was kept busy throughout the trip keeping the wounds clean Hand bu[illegible] application [illegible] cream and [illegible] The day to day [illegible] course had [illegible] they stood [illegible] Rates whose [illegible] or stand-on [illegible] conduct of [illegible] themselves [illegible]

The [illegible] casualties had ceased came simply as a [illegible] relief Before we were able to return home we had to make our 3rd trip to Montevideo We did have one fairly sick casualty on that trip but we also carried an RN surgical support team (or part thereof) required to return to UK early Rearming of their exploits in the war zone I recall feeling slightly humbled that we had had such an easy time in comparison

In late June we commenced the 4 week passage home The trip itself was uneventful but our arrival in Devonport on Friday 30 July 1982 was not We returned to an unexpectedly warm enthusiastic and moving reception in the Naval Base on one of my most memorable days And so ended a very special period of my life in HMS HECLA in the South Atlantic It really was an honour to have served with such a kind and generous ships Company and to have played a small part in the success of Operation Corporate

And the Type 21 that I was denied ? HMS ARDENT

Surgeon Commander Donald G Bruce Royal Navy Retd

The Falklands

SS UGANDA, A New Concept In Hospital Ships

R J Leicester

Despite press coverage of the attempted invasion of the Falkland Islands it wasn't until the actual invasion on 2nd April 1982 had I noticed the trouble of looking up exactly where the Falkland Islands were. Events accelerated rapidly from that point on with an unannounced mission to my old patient clinic the following Tuesday (April 6th). Lt Cdr Tee MOICs assistant who summoned me to the Captains office. I recall rebuking him for disturbing a patient consultation despite the international emergency and said I would go as soon as possible. A brief interview with the Captain indicated that I was to design and staff a maintenance ship to proceed to the Falkland Islands to support HMS CANBERRA which was being converted into a dual purpose hospital ship and assault carrier. Having been involved in a similar exercise in the Eastern Mediterranean two years previously where I had to set up an emergency isolation facility in an RFA I had a reasonable knowledge of the Geneva Convention on Hospital Ships. My reservations of the dual purpose HMS CANBERRAS role stating that I would prefer a dedicated hospital and assault ship so that in the event of my ship being sunk during the medical operations HMS CANBERRA could transfer to a fully functional hospital ship.

On Tuesday 6th April I visited Surgeon Captain Watkins on board SS CANBERRA and discussed plans for conversion and I was told that I was to join the ship but said I'll plan for the refit and adjust in case the Government understandt. The PERSIA set sail for the South Atlantic on Friday 9th April I drove to Portsmouth where ships were available for storing ship conjunction with the Falklands operation to requisition suitable ships and had

SS UGANDA

accommodation for 940 students and 143 dormitories fitted with two tier bunks and 304 cabins for first class passengers together with numerous large common rooms ballrooms and lounges. I then drove on to RNH Stonehouse to work on equipping the ship. It was at this time I realised that Margaret Thatcher had no intention of giving in to Argentina. Every door I knocked on was wide open and I was able to procure whatever I wanted with no questions asked. The items were based around a field hospital as this was all that DMSSU Ludgershall had catalogued. Further items were ordered to equip a proper laboratory ITU and beds for an acute hospital facility.

Four days later on 13th April I flew from Gatwick to Naples with two P&O engineers the only 3 passengers on a chartered Boeing 737. With details and plans of SS UGANDA laid out on the deck of the aircraft we planned her conversion into a hospital ship. Arriving at the dock in Naples we were greeted by hundreds of British schoolchildren singing Rule Britannia who were swiftly disembarked having had their cruise curtailed by 2 days. As the only representative of HM Forces I then had the task

of explaining to the Captain, Brian Biddick, the future role of the ship and what we would like to do in the way of training areas. During the two day voyage to Gibraltar we worked contentously, particularly to place our plans in order that equipment could be ordered in time for a major refit at Gibraltar which entailed installing a lift, flight deck, desalination plant plus additional communications, navigational and RAS equipment. Dockyard and senior P&O personnel arrived en route via helicopter in order that work on conversion could start immediately on arrival in Gibraltar. Unfortunately the announcement to the crew inspired fear amongst many of the largely Goan crew members who decided to leave en masse in Gibraltar and required a rapid call up from the NUS pool in UK to allow the ship to become operational.

Arrival at Gibraltar on the evening of 16th April marked the start of feverish activity on behalf of the newly arrived NP1830 in loading the tons of stores which had been ordered from UK and the dockyard workers who set about converting SS UGANDA from an educational cruise ship to an operational hospital ship. My first port of call the following day was RNH Gibraltar to retrieve the emergency surgical supplies which I had left there two years earlier (following deployment in the Eastern Mediterranean) and had been maintained in a sterile condition by the theatre staff on a regular basis. This allowed the ship to be fully operational for surgery (using the ship's existing hospital facilities) whilst the contents of a field hospital (mmus tents) and other stores were unpacked and identified.

A little under 72 hours later SS UGANDA sailed in her new livery of a hospital ship (Pennant 21) under the rules of the Geneva Convention. Tragically our first casualty was Captain Brian Biddick who required an emergency operation less than 12 hours after leaving Gibraltar before being casevaced from Sierra Leone during the voyage south. Setting up the hospital facility continued intensive training commenced tutoring RM bandsmen into paramedics and nursing staff into ITU and operating theatre staff. By the time of arrival off the Falkland Islands

Surgeon Commander R J Leicester Royal Navy Retd

The Falklands

Operation Corporate – Falklands 1982 - Some memories

J Massey

Joining QARNNS in 1968 the expectation of going to a war was far from my mind. I recall very little information or training being given about my war role. Suddenly from being a ward assistant in RNH Plymouth I was removed from my duties and began preparations to go to the Falklands. About 10 days later I met up with colleagues from RNH Haslar at Lyneham we flew via Gibraltar the journey was probably the most uncomfortable part of the next 112 days aboard SS UGANDA in the dockyard and during for the first time the red crosses on the funnel. Like I believe many others I was nervous for the first time. This is for real. We were told of our journey south and of the busy setting up the hospital ward operating at 1200 daily to listen to the BBC World News played throughout the ship, for some while expecting we would be turning round and heading home. Seaview ward where I worked was under the flight deck luckily we were not aware of the helicopters landing above our heads. Our life was busy initially scrubbing out the ward assessing what equipment we had and what other essentials we needed. Finding out what we could find in the ship such as crates to lash to the deck to store the equipment. Spirit bottles for the bar for the lotions. Making clip boards for the end of beds for patients notes and also trolleys so equipment did not fall off the tables. Bottles as weights for traction. Hot and cold sea water set up by P&O breaking into the sea water system to the heads so with a hose rubber hose and heavy duty gloves we could drink with bed pans. Ingenuity required in many things.

Discussing how we would run the hospital for nursing watches and duties throughout the twenty four hours. Theatres on condition we would have to deal with training the Royal Marines in basic nursing skills. These very helpful and marvellous young men helped in the wards where they were not carrying patients around the ship with great skill from the flight deck to wards and departments.

Arriving at the total exclusion zone and sailing about in our Red Cross Box. Therefore even eg the announcement that we were going into Falkland Sound. In the darkness the ship brightly lit sailed silently. On deck somehow the atmosphere changed. We were all ready and could do no more to prepare for the unknown task ahead. Would I cope with and be able to do what was expected of me?

Then the daily arrival of casualties and duties throughout the 24 hours. British and Argentine patients together in the ward. The British patients sorry for them as individuals. Sorrow that the Argentines were conscripts. At least we are volunteers "was said to me. Uncomplaining patients watching when further casualties came into the ward looking for any they knew. It was amazing how quickly new arrivals spirits were revived. Probably feeling safe in SS UGANDA in a bed being able to rest and having some female nurses to look after them.

Getting up at for duty at 2359 and other nights at 0400 walking around a quiet ship going to the restaurant for a drink and left over sandwich and walking to Seaview. Walking on the outside deck to get to the ward – day or night never knowing quite where we were. Some times at sea the ship moving in the darkness with nothing else around. sometimes at anchor in Falklands Sound and the sight of land

Most patients [illegible] fly [illegible] night but pain and anxiety [illegible] patients all night someone [illegible] or all of the conflict the [illegible] about families back [illegible] patients frightened [illegible] with no obvious [illegible]

The staffs on my team [illegible] Staff Nurses SENs and Medical Assistants were magnificent as expected Always there on time reliable cheerful and hard working Sitting with them at night and being introduced to the delights of Boggle getting tired together but also the laughs Daily our friendly and very helpful Zac who worked in the Bureau would come very early to help with our morning routine – washes temperatures bed pans He became an important and very necessary member of the morning team leaving us to get on with the very time consuming injection round The joy of having the opportunity to spend one night in three in bed coming off duty at 2359 and returning at 0800 a night of peaceful sleep Coming off at 0800 meant a couple of hours uninterrupted sleep before the broadcasts began Hands to Flying Stations We could tell the level of casualties being admitted that morning by the [illegible] and [illegible] pressing [illegible] ward [illegible] tiffy tours One [illegible] how [illegible] Every other [illegible] of patients sitting [illegible] with blackened hands [illegible] with hands in polythene bags As [illegible] towards them they all seemed to [illegible] look at me I understood why the ship was quiet all available personnel were setting up the planned extra wards

The return to Southampton was memorable for the exciting welcome and seeing ones family and friends

Twenty five years on a definite Falklands experience while never to be forgotten has taken its place in the memory with other life's events Recently taking part in Falklands events I have met with those who have made the conflict their lifes work calling for the welfare of Falklands veterans For a number of those we cared for in SS UGANDA memories will be a daily occurrence living with their very visible physical casualties

Captain J Massey RRC QARNNS Retd

The Falklands

Falklands Hospital Ship - SS UGANDA

A J Rintoul

The Ship

It was 10 April 1982 and preparations for war in the Falkland Islands were already well underway. At 8000 miles from the UK and the nearest airfield at Ascension Island 4000 miles distant it was soon realised that a dedicated hospital ship was vital to provide theatre support and CASEVAC back home.

A P&O liner SS UGANDA was requisitioned. This was a 17000 ton ship with cabin accommodation for 320 passengers in formatory accommodation for 940 students and a magnificent 516 foot long flat upper deck promenade deck well suited for a hospital. The disadvantages were the lack of a full double bottom water ranking capacity and a single screw giving a top speed of barely 12 knots.

UGANDA's passengers and scholars were disembarked at Naples and she sailed at full speed for the Royal Naval Dockyard Gibraltar. Within 65 hours all light deck and an access ramp were erected and the promenade deck prepared to the hospital.

Our 128 strong Naval Party 1830 included communications flight deck supply personnel and 24 marine bandsmen who were to act as stretcher bearers. Awaiting us on the dockside was an army field hospital of 200 beds one base medical stores and one RN major surgical dressing chest amounting to about 90 tons. Within 65 hours the refit was complete and we sailed on 19 April with specialist facilities in general medicine surgery burns public health pathology radiology psychiatry

ophthalmology surgical surgery supported by a medical administration team.

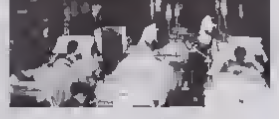
The voyage South

During the voyage South about 17 days the hospital was set up and a programme of lectures and casualty reception exercises was carried out. We stopped briefly at Freetown (for refuelling and at Ascension Island (for shore leave) where we received a stores deficit of 180 items and 2 desalinators and sailed within a few hours.

The planned role for Uganda was to take up position in a Red Cross Box 100 miles North of the Falklands with casualties being brought by 3 dedicated hospital transports (hydrography ships HMS HECLA, HYDRA and HERALD).

Actron

By 5 May we were in our allotted position when we received news that HMS SHEFFIELD had been attacked, suffering major damage with many burns casualties. With the help of the ships engineers we set up an 18 bed burns unit with positive pressure ventilation and transmitted signal informing Commander Task Group (CTG) of our new capability. A flash signal was received with orders to proceed at best speed to the 200 mile Total Exclusion Zone (TEZ) and the first casualties arrived on 12 May, one of which had 44% burns. This effectively changed our role from casualty transport to the reception of casualties by helo direct from warships from Ajax Bay field hospital and eventually from the battlefield. The hospital transports dropped back to a casevac role between Uganda and the RAF casevac system at Montevideo, Uruguay. By 25 May we were in Middle Bay and 3 days later in Grantham Sound just over the hill from San Carlos Water (Bomb Alley). At this time the International Red Cross in Geneva received a warning from Argentina that UGANDA was too close to the battle zone and that her safety could no longer be guaranteed. CTG was also concerned that the illuminated hospital ship with her 12 foot red crosses could be used by enemy pilots as a navigation beacon. Orders were received that UGANDA must leave Grantham Sound before nightfall every day returning at first light.



had been so reduced with the [illegible] so that Uganda had to arrange daily [illegible] and position [illegible] the TEZ. On 4 June a [illegible] Argentine Puma helicopter took itself and its [illegible] transport party on board. Static [illegible] were received at this [illegible] over the medical facilities which we found adequate. [illegible] between 11 [illegible] it was the first of a number of such transfers to Bahia Paraiso and later to a second hospital ship Almirante Irizar.

On 9 June LSL SIR TRISTRAM and LSL SIR GALAHAD were [illegible] and by daybreak as soon as we were within helo range casualties arrived by any type of helicopter available. By dusk as we were forced to leave Grantham Sound casualty addon helicopters continued to follow us and by the time we were out of range we had received 159. All off duty P&O staff were recruited to move casualties throughout the hospital deck and dormitories and hand feed and wash those incapacitated with burns. By then we had more than 300 casualties on board. Hospital staff numbers had been augmented by the arrival of nursing staff from UK and medical and nursing staff from the troopship SS CANBERRA. We also borrowed a medical officer and a medical assistant from each of the returning hospital transports. The enormous quantities of medical stores required were flown to Montevideo and brought to UGANDA.

Deregistration

UGANDA then became a hospital ship for home on 18 July with 600 Gulf War Old Ambulance on board. It was stated should be maintained at full readiness were out of helo range 300 miles from a non stop voyage of 22 days. Uganda

Aftermath

Conclusion

Captain A J R Rose Royal Navy (Retd)

J Royal Naval Medical Service 2007 93 2 67 74

Clinical

An Analysis of Smoking Demographics in HMS DRAKE and an Update on Smoking Cessation Support

T Pepper

Introduction

Smoking is the largest single cause of morbidity and premature death in the UK[1]. It is a major aetiological factor in numerous cancers, coronary artery disease, peripheral vascular disease and chronic obstructive lung disease. It is also associated with a wide range of conditions including cerebrovascular accident, reduced fertility, impotence, peptic ulceration, visual deficiency, miscarriage, low birth weight, osteoporosis and periodontal disease.

These conditions, as well as less severe ones to which smokers are more susceptible, place a significant burden on any medical system. Indeed, the annual cost to the NHS of treating patients with smoking-related diseases is in the order of £1 500 million[2]. As such it is evidently in the interests of both the patient and the medical system that serves them, to reduce the prevalence of smoking.

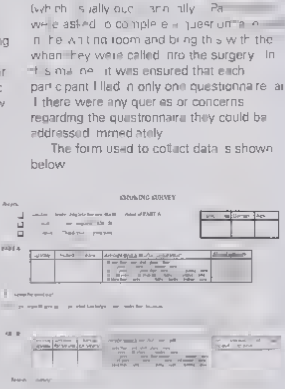
This paper is intended to showcase some of the smoking demographics in HMS DRAKE, as well as providing a reminder of the ways in which health care workers can contribute to reducing smoking.

Method

A cross sectional survey was conducted over six months, utilising a convenience sample of personnel in HMS DRAKE. Royal Marines and submariners were not included in the survey population. Chaplains were also excluded due to their variable position in the rank structure.

The questionnaire was administered to [illegible] other naval personnel undergoing [illegible] HMS DRAKE for periodic dental inspection (which usually occurs annually). Patients were asked to complete the questionnaire [illegible] in the waiting room and bring this with them when they were called into the surgery. In this manner it was ensured that each participant filled in only one questionnaire and if there were any queries or concerns regarding the questionnaire they could be addressed immediately.

The form used to collect data is shown below.



No information that could be used to identify participants (e.g. name, service number) was collected, and participation was entirely voluntary. The questionnaire was intended to collect data pertaining to smoking status. For those participants who were smokers or who had previously

smoked [illegible] was collected [illegible] average alc [illegible] requested [illegible] their [illegible] cumulative [illegible] subsequent [illegible]

The [illegible] formally [illegible] and following this [illegible] the choices [illegible] drink quantities [illegible] as this was perceived [illegible] understood by the population.

An open question [illegible] regarding motivation [illegible] in order to [illegible] answers. Resp[illegible] predominant [illegible] [illegible]

[illegible] 100 [illegible] only [illegible] The [illegible] reasons for smoking [illegible] participants also entered the reason they had started smoking (e.g. peer pressure) rather than the reason for their continued smoking status. This resulted in a reject rate of 8.1%.

Results and Discussion

The survey participants are representative of the lower end of the rank spectrum within the surface ship and shore establishments in HMS DRAKE. There were few participants over the rank of Lieutenant. In order to take into account the smaller sample size of higher ranks, graphs have been based on percentages of smokers, ex-smokers and non smokers rather than absolute numbers.

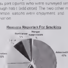
The survey results provide some answers to the following questions.

What proportion of the surveyed population were smokers?

According to results in HMS DRAKE, 28.5% of participants smoke, 20.0% used to and 51.5% have never smoked (please see result 9 for [illegible]). This is slightly higher than the proportion of smokers in the UK. In 2004/05 [illegible] prevalence was 25%, 24% were ex-smokers and 52% had never smoked[3].

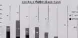
1 What makes people smoke?

Most participants who were surveyed smoked through habit (addiction). The two other most common reasons were enjoyment and relaxation.



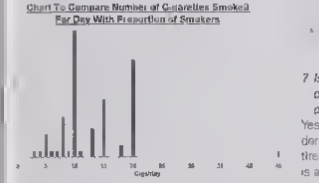
2 Which rank has the most smokers? Which has the least? Is there a trend?

The AB rank has the highest proportion of smokers. The rank of Commander (the highest participating rank) has the lowest. On the whole, the higher the rank, the smaller the proportion of smokers. This may well correlate with national trends in which smoking rates are lowest among socio economic class A, and increase through to class E[4].



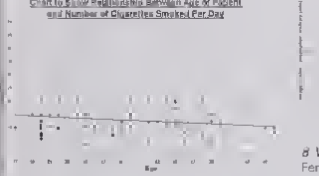
4 How many cigarettes do most people smoke?

There was a bi modal distribution of data. Most participants (30%) smoked 10 cigarettes per day closely followed by 20 cigarettes per day (23%). Only one participant surveyed smoked more than 20 cigarettes per day.



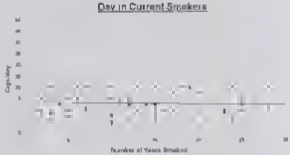
5. Is there any relationship between the age of the smoker and the number of cigarettes they smoke?

Not really. There appears to be a very weak trend which indicates older smokers smoke slightly fewer cigarettes per day.



6 Are people that have been smoking for longer likely to smoke more?

No. Overall there appears to be no association between the number of years smoked and the number of cigarettes smoked. However, looking specifically at the data for ex smokers, there is a weak trend showing that the longer a participant had smoked the greater number of cigarettes per day they smoked.

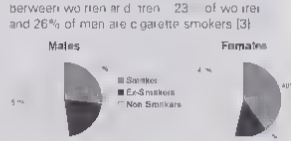


7 Is the number of cigarettes smoked correlated with the amount of alcohol consumed?

Yes. Alcohol consumption for each group was derived from mean of the alcohol self-score on the questionnaire. According to the results there is a relationship between smoking and alcohol consumption. Participants who smoked greater numbers of cigarettes per day were likely to have a higher weekly alcohol consumption. This relationship is possibly due to the social convention of drinking and smoking together.

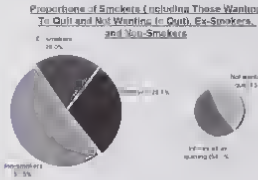
8 Who smokes more – males or females?

Females: 40% of females were smokers compared with 27% of males. In the general UK population prevalence is much closer between women and men: 23% of women and 26% of men are cigarette smokers [3].



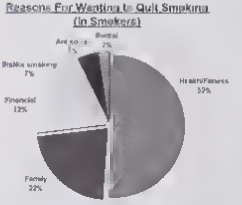
9 What proportion of smokers was interested in quitting?

Overall 54 of [illegible] give up. This [illegible] statistic which states that 7 [illegible] wish to give up[3]



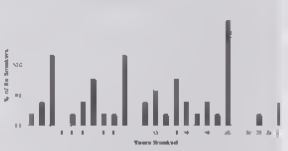
10 What makes smokers want to quit?

Most participants [illegible] health/fitness family [illegible] respectively. This is very [illegible] motivation which [illegible] financial and [illegible] often cited[5]. Financial [illegible] further down the list of motivators to quit in service personnel due to the availability of cheaper cigarettes. The grounds on which most ex-smokers in HMS Drake stated that they had actually quit were health/fitness



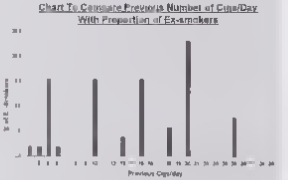
11 Are people [illegible] have been smoking a long [illegible] ready to give up? How many years have people usually smoked for before they quit?

[illegible] 20 years was the modal smoking [illegible] prior to giving up. There appears to be [illegible] relationship between numbers of ex [illegible] and years smoked.



12 Are people who are heavy smokers less likely to give up than those who smoke less?

No. According to the data a large proportion of the ex-smokers smoked cigarettes in numbers at the higher end of the scale (38.5% used to smoke 20 per day or more). However the spread of data is loose.

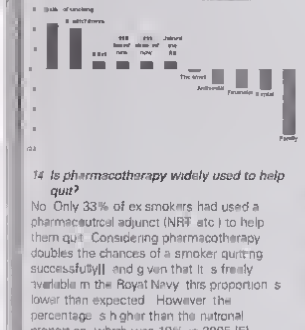


13 What was the most powerful impetus to quit smoking? (i.e. What is the motivating factor that makes smokers quit successfully?)

Although most participants had quit for health/fitness reasons the most powerful motivator for quitting was a dislike of smoking. For instance, 22% of smokers stated that they wanted to quit for family reasons. However this percentage wasn't borne out in the ex-smokers – only 6% of these stated that they had actually managed to quit for family

reasons. Therefore although family reasons was a commonly stated reason for wanting to quit, it was not a very powerful motivation to successfully quit. Conversely, ex-smokers said they wanted to quit because they no longer liked smoking. However, 12% of ex-smokers said they quit successfully because they began to dislike smoking – this is therefore a powerful impetus to quit.

Relative strengths of motivating factors were calculated through comparison of numbers of smokers wanting to quit for a particular reason and the number of ex-smokers who had successfully quit and stated the same reason.



14 Is pharmacotherapy widely used to help quit?

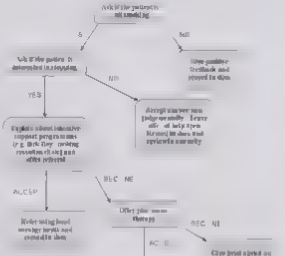
No. Only 33% of ex-smokers had used a pharmaceutical adjunct (NRT etc.) to help them quit. Considering pharmacotherapy doubles the chances of a smoker quitting successfully[1] and given that it is freely available in the Royal Navy, this proportion is lower than expected. However, the percentage is higher than the national proportion which was 19% in 2005 [5].

Smoking Cessation Support

Three tiers of smoking cessation support exist:

1. **Brief Intervention**. This is opportunistic, succinct advice to encourage smokers to quit and point them to effective treatments. Brief interventions should be delivered by medical officers, dental officers, nursing officers, medical assistants and dental hygienists. All smokers should receive a brief intervention, which, historically has been based on the five As[7]:
   - Ask if the patient is a smoker
   - Advise them to quit
   - Assess their willingness to make a quit attempt
   - Assist them by providing support and treatment
   - Arrange referral to a specialist cessation service

Brief interventions, which have been shown to increase smoking cessation success rates[8], should be delivered by health care professionals[9]. However, the aim of a brief intervention is to trigger a quit attempt. Most smokers make several attempts to stop (on average 3-4) before finally succeeding – therefore relapse is a normal part of the process[7]. Annually, only 3-6% of smokers who attempt to quit will succeed[1,2]. Those who want to quit should be offered a referral to intermediate support (i.e. a smoking cessation clinic). If this is declined, pharmacotherapy should be offered in line with the abstinent-contingent protocol (see below). Those who do not want to quit should be reviewed annually.



(Redrawn from NICE public health intervention guidance. Brief interventions and referral for smoking cessation in primary care and other settings. March 2006)

2. Intermediate Support [illegible] dependent smokers.

3. Specialist Services – [illegible] cessation clinics lead[illegible] brief interventions but [illegible] success rates (10-20%) [illegible] well motivated to stop [illegible] of methods unsuccessful [illegible] referral. At present this level of support is only available through NHS Stop Smoking Services (0800 1690169).

Pharmacotherapy

Smoking cessation pharmacotherapy is among the most cost effective of health care interventions. Even the most expensive smoking cessation intervention is considerably more cost effective per life year gained than the average of more than 300 medical interventions[6]. Consequently pharmacotherapy should be recommended for all smokers who have expressed a desire to quit smoking unless medically contraindicated.

- *Nicotine replacement Therapy (NRT)* – At present there is insufficient evidence to indicate whether one form of NRT (i.e. chewing gum, transdermal patch, etc) is more effective than another, but trials a combination of two different forms of NRT was more effective than a single form[2].

  NRT may be prescribed by medical and dental officers. It is recommended that the smoker should have stopped smoking before commencing NRT and the treatment should be discontinued if the patient [illegible] smoking. Initial prescription should be for 2 weeks with a second prescription if the patient demonstrates their quit attempt is successful on reassessment [illegible] with a carbon monoxide monitor). This is the abstinent-contingent protocol (ACP) and ensures that patients have continued contact with support services as well as preventing over prescription.

- *Bupropion Hydrochloride (Zyban)* – This is a prescription only selective inhibitor of the neuronal uptake of dopamine and noradrenaline. As such it is also used as an antidepressant drug in the USA. The exact mechanism of action on smoking cessation is unclear but it is thought to act on central pathways involved in addiction and withdrawal. Bupropion may be prescribed by medical officers only.

  Approximately 1 in 1000 patients may experience bupropion-associated seizures as a side effect[10]. Consequently it is not recommended as first-line treatment in the Armed Forces.

At present there is insufficient evidence to conclude whether NRT or bupropion is more effective in aiding smoking cessation or whether there is any merit in combined therapy[11]. What is known however is that either treatment modality doubles the chances of a smoker successfully quitting[7]. Some smokers who are unable to quit using NRT will be successful using bupropion and vice versa.

Future Therapeutics

Drugs that are not yet licensed for use in the UK to aid smoking cessation include:

- *Varenicline* – This is an orally administered partial agonist of the $\alpha 4\beta 2$ nicotinic acetylcholine receptor. Consequently it reduces the satisfaction that smokers derive from smoking. It has been licensed for use in the USA under the name Chantix and has been approved by the European Commission under the name Champix[12].

- *Rimonabant (Acomplia)* – This is a selective blocker of the cannabinoid CB1 receptor. It is claimed that therapy with rimonabant is associated with weight loss, favourable changes in serum lipids and an

[illegible] SIMPLE guidelines recommend referral straight to specialist services from brief intervention [illegible] for those who wish to quit.

improvement in glycaemic control in NIDDM. In addition to these well-established pharmacological agents, significantly increases smoking quit rates compared with placebo[13].

- *TA NIC*. Clinical trials of the TA NIC vaccine against cocaine have been ongoing. TA NIC is a conjugate vaccine consisting of a cocaine derivative covalently linked to a recombinant form of the non-toxic B subunit of cholera toxin. The vaccine is presented to the immune system via intramuscular injection, which leads to the development of antibodies to cocaine. The antibodies bind to cocaine in the bloodstream and the resulting complex is too large to pass through the blood brain barrier. Hence the pleasurable effects associated with smoking cocaine are postulated that a short course of vaccination will be required to modulate the dose-related effects of antibody response[14].

Conclusions

Smoking is obviously an important issue for the Royal Naval Medical Services both for reasons of reducing ill health and promoting optimal health[2][15]. However, a greater proportion of personnel appear to smoke in the Royal Navy than in the general public, additionally smoking is of great prevalence in female service persons.

The prevalence of smoking in the Warrant Officer rank and above is particularly low, in fact 97% of all smokers in this survey were in the Chief Petty Officer or lower ranks. Therefore it may be especially cost effective to target specific health promotions at these ranks.

Those patients which may logically be considered the most unlikely to quit – the heavy and/or long-term smokers – are in fact the ones most likely to quit.

In the USA several barriers to cessation have been identified including lack of time, perceived lack of skills and the perception that success rates are low[16]. Health professionals who have received training are

Acknowledgements

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Hea
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[b]Smokers' levels of physical fitness improve less with training than [illegible]

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Case Study

Vertebral wedge fracture after speedboat 'splash down'

G Wild

Abstract
A case is presented of a soldier with wedge fracture of T12 sustained after an axial compression (flexion) injury in a Rigid Hull Inflatable Boat (RIB). Very powerful boats such as RIBs are used on a daily basis in the Royal Navy (RN). Despite this, fractures of the spine are unusual (1). This study explores the mechanism of injury and illustrates that a wedge fracture should be considered in anyone presenting with back pain after a splash down injury.

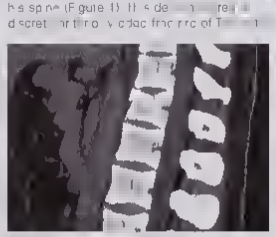
Keywords
Powerboat, speedboat, thoracolumbar, vertebral fracture

Case Summary
A 26 year old Army Lance Corporal was riding as a passenger in a RIB in the Bay of Gibraltar as part of a familiarisation visit. He was in the bowman's seat which is situated behind the coxswain (driver). The seat is cushioned and has a cushioned back support.

Conditions were very calm but the RIB passed over the wake of another vessel resulting in it becoming airborne. The RIB splashed down and the LCpl had a transient loss of consciousness. There was eyewitness evidence that he may have been bent forwards at the time of impact. The next thing he can remember was lying on the bottom of the boat and immediately reporting pain in the middle and lower portions of his back. The three other personnel who were in the RIB at the same time were uninjured.

The patient was brought to the Joint Medical and Dental Unit (JMDU) where he was initially assessed. He had no other neurological deficit, no bladder [illegible] compromise but he was [illegible] thoracolumbar junction [illegible] fracture was suspected and he was sent to the Royal Naval Hospital, RN[illegible] x-ray [illegible] spine (Figure 1). It was decided [illegible] discretion, a thoracic fracture of T[illegible]

Figure 1: Lateral thoracolumbar [illegible] wedge fracture at T12



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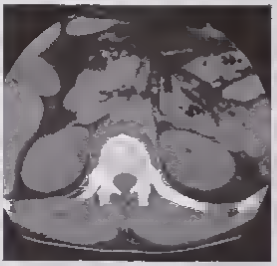

Discussion

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n n Tornado

have d s ud es on young adults have own that the nta vertebral d scs are mo e es stant to axial loading than the vertebral bodies(8) The lower thoracic sp ne is mora p one to injury because the vertebral colun n at th s laval has the h ghest loading per unt a (9) Even a slight amount of flex on can ma kadly reduce the amount of stram the ertebral column can withstand because it eases the forces imparted on the anter or t rto o of the vertebral bod es(5) Conversely l pe ev ens on with subsequent transfer o p t of the load to the facet j nts means that sp e can tolerate much h gher forces Th s l s a t cular relevance to wave jumpers s a t res bacausa there will nev tably bc e fley on of the sp ne on a hard water h G as he powerboat slows and the p t pants are thrown forwards

Conclusion

Middle and low back pain can be a
presentat on for vertebral wedge fractute

the drivers and passengers of powerboats. This information is especially pertinent to ships' medical officers. There should be a low threshold for radiological investigation which presents challenges if the mother vessel is at sea.

Bending forward in a flexed posture significantly reduces the amount of force needed to cause a vertebral fracture. This position should be discouraged in powerboat coxins and passengers. Occupants of powerboats should also be encouraged to use the foot restraints to reduce the effects of seat bounce. Indeed this is already included in the RIB safety brief(10).

Interestingly the patient presented in this case and all the patients in the one other case series were passengers. It could be possible that passengers are at greater risk of injury as they are often inexperienced on the water and unable to see ahead. This makes it difficult for them to predict a hard impact and pre-empt it with a better body position. The numbers however are small and cannot be considered to be statistically significant. Readers are encouraged to report any similar cases to the author.

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Surgeon Lieutenant Commander G WILD BSc MBChB MRCS, [illegible], Gibraltar BFPO 52

General

Out Of Programme Experience Auckland 2005

M I Tennant

In 2005 I was privileged enough to be permitted a 12 month period of Out of Programme Experience at Auckland City Hospital in New Zealand. Serving Auckland City Hospital serves a local population of approximately 350 000 and it is the tertiary referral centre for the entire North Island. As such it therefore provides specialist medical cover for 75% of the population of New Zealand and provides the nation's only liver transplant unit. It was this latter fact along with the opportunity to work alongside Professor Alan Hall that sparked my original interest. Discussions had been established and I duly telephoned Professor Hall to ascertain whether I would have the opportunity to undertake hepatic anaesthesia for both vascular surgery alongside my oncology colleagues and the transplant team. Initial interest in agreement and Colonel Peter Turner, who had recently arrived in New Zealand from Iraq, had just about settled in to the Military Attaché role and gave me a valuable insight into the CPO responsibilities of the position pertaining to my stay. Initial accommodation was in the Intensive Care Unit working within the confines of the Auckland City Hospital complex. I lived within the confines of the Auckland City Hospital complex. I lived with the Police New Zealand Police Force and with many members of the Maori and Pacific Islands and San Cons 12 Field Ambulance in the latter category I was one of only a few Europeans on the list of immigrants. I was somewhat surprised to learn that I had Polynesian ancestry.

Auckland's substructure and of course the number of Maori Britons continues to increase day on day. This rich socio-economic mix not only provides the backbone for a terrifying production line of All Blacks but also offers up a number of interesting challenges to the newly arrived anaesthetist. From the requirements to learn a smattering of Tongan, Fijian, Samoan and of course Maori to appreciating the significance of the spare blue pillows that reflected the spiritual importance of the head in Maori culture. Conducting preoperative assessments through interpreters became second nature as did the acceptance of diabetes, renal impairment and obesity as commonplace occurrences amongst the Maori and Islander populations. Although I regularly encountered patients with a BMI that would fall into the morbidly obese category the distribution of adipose tissue differs greatly from that in Europeans and is much more uniform. 100 kg plus patients were not deemed out of the ordinary. Indeed the body habitus of many of the Pacific Islanders renders the BMI an impotent and useless tool. A further racial difference we were to both surprise and shock us was the discovery that young Maori girls have the dubious honour of having the highest smoking rate of any cultural sub group in the world. This combined with a trend towards obesity in childhood obesity means that New Zealand is facing a public health time bomb similar to that widely recognized in both Europe and the United States.

Demographically as well as racial and cultural differences, gender specific problems that I too was unfamiliar with until my arrival. The population of the Pacific Islands and the limited secondary care available leads to the deferment of late presentation of many common conditions leading to a variety of rare syndromes

The distances travelled by many [illegible] staggering and because of this [illegible] family members was often limited [illegible] when available. It was frequently [illegible] However the hospital provided [illegible] waiting areas next to theatre and [illegible] specifically for the family group [illegible] camp out for the duration. A problem [illegible] one may not have immediately expected [illegible] arose from the status of a sizeable proportion of the elderly patient population as immigrants. Many of the Asians and Europeans had no medical records available prior to their arrival in New Zealand and so significant past medical events were unable to be assessed.

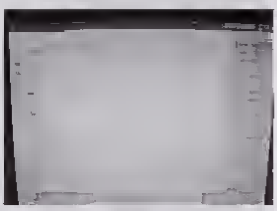
The practice of anaesthesia in New Zealand obviously encompasses the task of surmounting the problems and/or cultural nuances as alluded to described above. That said, the lists I undertook on a daily basis could be considered to be not far removed from those in an NHS district general hospital, with a few notable exceptions linked to Auckland's status as a tertiary referral centre.

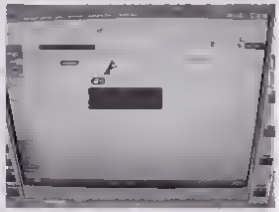
I think it is worth noting at the time of my arrival as a 4th year SpR, that my training in the UK equated to a newly appointed Consultant in New Zealand. This was a fantastic opportunity and one I relished from the start. One of my most frequent responsibilities was that of theatre coordinator, an over arching managerial style task that saw me endeavouring to ensure the smooth running of the 12 theatres in the main suite. This role also extended to include supervision of junior trainees in both general and orthopaedic acute theatres, the provision of ward reviews and the receipt of emergency referrals. Some of the more challenging moments involved the delegation of lists and reorganisation of manpower in the event of illness and the necessity for provision of services for CT and neuroradiology and often employment of delicate negotiation skills with senior colleagues and surgeons desperate for their list to over run!

With the relatively recent drive to establish a "best practice" in the UK of utilising ultrasound in the establishment of central venous access, Auckland Hospital provided me with invaluable experience in the techniques its application. At [illegible] und and [illegible] o a trend [illegible] venous [illegible] nd [illegible] techn[illegible] plexus blocks [illegible] to be an incredibly [illegible] ward undertaking [illegible] and at the very least [illegible] rasound machine with a [illegible] at the plethora of bur[illegible]

The relatively [illegible] ealth care system in New [illegible] d change and the adoption [illegible] paperless that is to be en[illegible] standard [illegible] could be argued that [illegible] differing [illegible] electronic patient [illegible] this ability of the [illegible] full use of the [illegible] patients previous [illegible] into a central [illegible] the PC on each [illegible] computers also [illegible]

A [illegible]





Screenshot showing discharge summary note the hyperlinks to the side

"CG and even occasionally ECHOs completed on the same day. Allocated cardiology clinic space and an assigned preoperative cardiologist allow one to fully work up individuals and also provides an invaluable learning experience. More complex patients or procedures warrant 90 minute appointments and the thoroughness with which this allows guarantees that the cancellation of a patient is extremely rare and promotes admission on the day of surgery for even the largest cases. I have had a huge amount of medicine from allied specialties began beta blockers when operated, walked the patients up flights of stairs and all the things I wish I could do more physiology before surgery. Upon finishing a procedure, I was then able to dictate directly into the PC in my room and view and edit the report of that procedure at the next day on the

seemingly technology and the drive to improve outcome working in perfect harmony.

I previously commented on the similarity of the New Zealand system to that in the UK. However, provision of an Obstetric and Gynaecology service proved to be a notable exception. With a separate theatre suite isolated from the main suite, the anaesthetists employed there had little or no contact with their colleagues merely a floor below. Having a declared interest in obstetric anaesthesia I found this concept somewhat startling to begin with, together with as too the regular appearance of "private" midwives and anaesthetists. Topping up an epidural which had magically appeared courtesy of the private service overnight was an odd undertaking.

Two points of particular interest arose from my experience in Obstetrics. Firstly, all labour and post operative epidurals employed [illegible] as their sole agent. I was suitably intrigued by this and endeavoured to search [illegible] work on the subject only to discover that Auckland was the only major centre routinely using such epidurals in obstetrics. This lead me onto the second point of interest, namely a dedicated obstetric pain team. It is from their scrupulous recording of post delivery/operative pain scores, motor block and other side effects that one could gather extremely convincing evidence to support the efficacy of these [illegible] epidurals. From their extensive records of over 5 years experience it appears that the most troublesome complication post section is ironically unrelated to the epidural being [illegible] neuropathic abdominal pain, a phenomenon to which I will attest to being unaware of previously. Regardless of whether the incidence of this reflects better post operative surveillance or a cultural sub group anomaly it still served as a timely reminder that the supposed "simple" LSCS still carries with it the capacity to have significant post operative morbidity.

They change their clime, not their frame of mind who rush across the sea. A quote from the Roman poet Horace circa 30 BC commenting on the lamentable qualities of his

[illegible]

[illegible] offered not only the chance to experience [illegible] practice but also provided [illegible] challenges posed by the imposition of leadership and management responsibilities. The acceptance and mastery of new techniques and the chance to look at old problems from a differing but parallel perspective also has the incalculable benefit of holding up your own practice to close examination.

I must thank the Anaesthetic Department at Auckland City Hospital for providing such a welcoming and professionally rewarding environment. My thanks also go to those naval deanery and college authorities who approved this fellowship from which I gained such decidedly clinical and educational benefits.

Surgeon Lieutenant Commander M I Tennant Royal Navy

General

The Armed Services Consultant Appointment Board (ASCAB)

R Heames

Introduction

All medical and dental officers of the Armed Services who are candidates for consultant status are required to appear before an appropriate Armed Services Consultant Appointment Board (ASCAB) [1]. The Board sits in lieu of the NHS Appointments Advisory Committee (AAC) for consultant appointments because current regulations state that Service Medical Officers are exempt from attending an AAC [2,3]. This article has been written from an anaesthetic perspective but is broadly applicable to all specialities in all three services.

Purpose

The Board is constituted to mirror as far as practicable the NHS process to ensure that military candidates are suitably assessed before appointment as consultants in the Defence Medical Services. However one major difference is that the ASCAB is non competitive. The Surgeon General (SG) has the authority to appoint an individual to consultant status not to a specific consultant post. Therefore the questions are more general and not aimed at a specific job. Each ASCAB has to satisfy itself that the applicant is by qualification training experience and personal qualities as suitable for advancement to Consultant status as their own line of enquiry. Once appointed to the Clinical Consultant Cadre service medical officers will be settled in the Armed Services would not normally be resubmitted to an Appointment Board for posting to a military unit but may be required to be interviewed before taking up an appointment within a NHS Trust.

Process

In your final year as a trainee you need to have discussed where you wish to work and in what capacity with your Single Service Consultant Advisor (CA) and the Defence Consultant Advisor (DCA).

1 Obtain Certificate of Completion of Training (CCT) and General Medical Council (GMC) Specialist Registration

The first action is to get your CCT and get included on the GMC specialist register. In order to get your CCT you need to hold a National Training Number (issued by DPMD) have completed satisfactory training and be registered with your Royal College.

Ensure that you get your final Record of In Training Assessment (RITA) at least 3 months before your expected CCT date to allow adequate time for paperwork to be processed. At that RITA you would expect to leave with a RITA. A Postgraduate Medical Education and Training Board (PMETB) [4] application form and any relevant Royal College application paperwork. The RITA panel will inform PMETB of your RITA which will then send your CCT on receipt of your Royal College recommendation your application and a fee (currently £500). At the same time as PMETB issue your CCT it will inform the GMC that you are qualified to become included on the Specialist Register and will send you an application form which you must return to the GMC (currently no fee) [5].

2 Apply for an ASCAB

In order to apply for an ASCAB the candidate needs to contact the ASCAB secretary at the

Defence Postgraduate Medical Deanery (DPMD) to obtain a MOD Form 1 (Application for Consultant or Senior Defence Medical Services) to be filled in template.

Applications are to be accompanied by the following documents:

a *MOD Form 423*

This overlaps with your CV in a number of areas but you will still need to enclose your CV as well. It covers your basic details, your training breakdown (which includes the name of your consultant/trainer), separate boxes for special skills learnt, teaching experience, administration/command experience and operational experience. There are also areas for presents/distinctions, publications, research interests, presentations and courses/meetings attended. Lastly, there is a box which you can add in any other factor which you feel may be of relevance to the board. This form then needs to be signed off by the DCA, the DPMD and MDG(N) or his representative.

b *An updated military CV*

No specific format is required but it should contain details of your military appointments as well as your NHS ones. DPMD will provide advice if necessary.

c *A copy of your CCT*

d *A copy of the GMC Certificate of Specialist Registration or a letter from the GMC confirming eligibility for entry onto the Specialist Register*

e *References from a Service consultant other than the DCA and from 2 other consultants (service or civilian) under whom the candidate has completed a significant attachment or academic course ideally within the last 3 years*

Before being submitted to the appropriate MDG for final approval, the candidate's application is to be checked by the DPMD to ensure that the supporting [illegible] are complete and to the [illegible] standard.

The ASCAB dates [illegible] have been completed, checked by DPMD, endorsed by your DCA, DPMD and MDG and all the interview panel members [illegible].

3 Attend the ASCAB

On the date is set you attend the ASCAB in civilian clothing which [illegible] in MOD Main Building. When all your will have received a list of the board members and these are composed as follows:

Voting Members	Non Voting Members
Lay Member across	DCA
Chair (a senior Civil Servant)	DPMD (or nominated deputy)
SG (or nominated deputy)	Secretary (from DPMD)
Royal College representative	
Civilian Advisor (service	
university rep)	
Medical Director	
(usually of MD/FU trust)	
NHS Trust manager	

Each voting member has the opportunity to ask questions and you need a majority of votes to pass. It is advisable to look all Board Members up on the internet (e.g. PUBMED [6]) to see where their research and interests lie. At the end of the interview you are asked to step outside whilst the Board deliberate and then you are called back in to receive the result.

Remember you must attend the ASCAB in person so ensure that the DPMD Secretary knows your deployment dates.

Board Failure

In the event that an ASCAB defers or denies approval for consultant status for any candidate, the Chair will prepare a formal written report setting out the reasons for the decision. The report will be addressed to SG. Copies should be sent to each member of the ASCAB, the DPMD, the DCA and the candidate.

It may not be initially obvious how the board can fail you when your Royal College/PMETB has given you a CCT. However if the Board identifies an area of

[illegible] ann re-at [illegible]

Pay/ Promotion

On receipt of your CCT and [illegible] registration certificate [illegible] send them on to the Appointer [illegible] you are appointed into a [illegible] consultant status (the [illegible] day as your CCT) the Appointer [illegible] the acting rank of Surgeon C[illegible] [illegible] is that your pay jumps [illegible] increment but you still [illegible] of [illegible] pay spine. If this [illegible] your annual incremental date [illegible] [illegible] plus two levels on the pay [illegible]

Success at ASCAB necess[illegible] appropriate paper work [illegible] over onto the consultant [illegible] your current incremental level. Th[illegible] [illegible] dated to the date MDG(N) [illegible] MOD Form 423 or the date y[illegible] consultant appointment [illegible] earlier. If you fail ASCAB the first [illegible] your consultant pay will only con[illegible] date of your subsequent success [illegible] AB.

Full promotion [illegible] getting confirmed [illegible] Surgeon Commander will only [illegible] recommendation and selection and [illegible] not necessarily occur in same year that [illegible] your CCT.

Possible Questions

What is the consultant interview trying to achieve? The interview panel need to know [illegible] you are medically qualified to do the job, you can communicate, you can function in a [illegible] you can lead, you can manage and that [illegible] they will [illegible] some [illegible] NHS works and [illegible] This [illegible] you [illegible] to [illegible] questions [illegible] about the [illegible] line [7,8]) [illegible] areas:

- *[illegible] / leadership*
- *Dealing [illegible] junior colleague*
- *Teaching [illegible]*
- *Weaknesses [illegible]*
- *Measuring [illegible]*

Clinical governance [9] [illegible] spread to come [illegible] in some way so you need to have a clear understanding of what the seven pillars are [illegible] Other current hot topics include:

- *[illegible] and their [illegible]*
- *[illegible] Medical Careers and [illegible]*
- *[illegible] Independent Sector Treatment Centre [illegible] / Private [illegible]*
- *[illegible] the NHS Plan [illegible] NHS Improvement Plan, Standards 4 Better Health [10-12]*
- *[illegible] for Health [13]*
- *Healthcare Commission [14]*
- *European Working Time Directive [15]*
- *Appraisal and revalidation [16]*
- *National Service Frameworks [17]*

Personal View of the Future

There are currently severe financial constraints on the NHS and this has led to a reduction in the number of advertised consultant posts. This problem will be compounded by an oversupply of doctors over the next decade. The result of this means that it is the personal responsibility of every trainee to make themselves as

marketable as possible with regards to their chosen career and their CV development.

As a trainee it is worth embedding in each department fully whichever hospital you work in. The benefit from doing this is that as you near the end of your training if you decide that you want to work in one of these hospitals it will pay dividends if they already know and like you. Remember they will be paying the Defence Medical Education and Training Agency (DMETA) a proportion of your salary and are unlikely to take you on if you train generally unhelpful.

It would not surprise me if in the future everyone will have to participate in a NHS AAC interview as Trusts will exert some control in whom they are employing especially if they are paying part of the salary. If you do not fall into the 'Good Egg' category why would a Trust want to pay 50% of your salary to have you 50-75% of the time. If I was a Trust Manager I would rather pay 100% of a salary to fully own someone and have them 100% of the time.

Remember preparation is everything. Good luck with your ASCAB.

"The best luck of all is the luck you make for yourself."
General Douglas MacArthur Supreme Allied Commander of South-West Pacific (1945)

Acknowledgements

I would like to thank the Defence Postgraduate Medical Dean Surgeon Commodore Noel Bevan for his help in proof-reading this article and ensuring up to date accuracy.

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Service News

Honours Awards and Citations

Queen's Honorary Physician

Surgeon Commodore NS Bevan OSTJ FRCGP RNTM Royal Navy

MBE

Lieutenant Commander Mark Trasler MBE Royal Navy

Academic Achievements

Surgeon Lieutenant Louisa Morris Royal Navy Diploma in Occupational Medicine

Surgeon Lieutenant Commander Chris Grange Royal Navy
Passed ASCAB Board

Surgeon Lieutenant Jayne McKinlay Royal Navy MRCP Part 2

The following personnel have been selected to receive a Commendation in Chief Fleet's Commendation for period ending 28 Feb 07

Surgeon Lieutenant M Scutt Royal Navy
Leading Petty Officer Medical Assistant J Argent
Leading Medical Assistant D Chamberlain
Medical Assistant M Long

Promotion

To Surgeon Commander
Surgeon Lieutenant Commander A R Gibson Royal Navy
Surgeon Lieutenant Commander S J Dickson Royal Navy
Surgeon Lieutenant Commander R M Bateman Royal Navy
Surgeon Lieutenant Commander A Duby Royal Navy
Surgeon Lieutenant Commander C G Streets Royal Navy

To Commander
Commander R A Stead Royal Navy

Transfer of Commissions

To FC
Surgeon Lieutenant Commander A Dow Royal Navy
Surgeon Commander A D Franklyn Miller Royal Navy

Placed on Retired or Emergency lists

Surgeon Captain R E Ashton Royal Navy
Surgeon Captain C R Kershaw Royal Navy
Surgeon Captain P C Runchman Royal Navy
Surgeon Lieutenant Commander J K McLachlan Royal Navy

Apologies to Commodore Reed who was inadvertently designated Commander in the last Edition. *Editor*

News

The Royal Hospital Haslar - 1753-2007

J Campbell

On Friday the 30th of March 2007 the flag was hauled down at the Royal Hospital Haslar thereby ending 254 years of service as a military hospital.

Many have spoken about the rationale of closing the United Kingdom's last standard military hospital. Much of the debate has been emotional. The recurring theme in all discussions has been one of intense admiration for this fine old institution.

On a wet and blustery day an essentially private "decommissioning" ceremony took place in front of the hospital to commemorate the end of an era in history. After a short service and inspection the Union Flag and the Ensigns were lowered to the tune of Sunset, ending Haslar's tour of duty.

The litany of her history's long and distinguished:

254 years
73 Commanding Officers and Matrons
Thousands of doctors
Tens of thousands of nurses, Medical Branch Ratings and technicians
An army of civilian workers
Hundreds of thousands of patients
A million memories
A host of smiles and a few of tears
Many triumphs and a few disasters
A home to many and a filter for some

Throughout her history the Royal Hospital Haslar was always at the forefront of military business. First open to patients in 1753 springing from noble aspirations she

provide excellent service to [illegible] patients of all services throughout [illegible] conflicts covering three centuries [illegible] peace. Bombed by the enemy and neglected by her parent [illegible] she survived over a quarter of a [illegible]

The [illegible] parents have always [illegible]. Having adapted over the years, [illegible] leading from the front, she kept [illegible] change. However, the demands of

modern wa fa
Hospital Has
The Royal H
provide on
pa reish pag
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Service the Jewu
Port on n wh ch she was
ense loyalty of the workforce
y and civ lian bear testament to her

The Royal Hospital Haslar was established to provide help and succour to the sick and wounded of the Fleet. She has discharged he duty

Surgeon Capta n James Campbell Royal Navy

Obituary

Surgeon Lieutenant Commander David Hughes MBChB FRCA 1969-2007

David was born in Torquay, one of six boys, and schooled in Newton Abbot and Exeter. He joined the Royal Navy in 1992, while a final year medical student at Dundee University. After his house jobs in RNH Plymouth and in Whitehaven, Cumbria, he completed his submarine training, followed by several patrols as the Medical Officer on the Trident submarine HMS Vengeance. On completion of his General Duties time, he returned to Devonport in 1996 to the Anaesthetic Department in Derriford as an SHO. During the war fighting phase of Operation Telic he was appointed as a resuscitation officer aboard RFA Argus where as well as Service personnel, he was involved in the care of many Iraqi nationals. After the gulf and a medicine post, David moved to Edinburgh for his Specialist Registrar training, passing his final FRCA exams in 2004. In 2006 he went as an overseas fellow to New Zealand, to gain experience in the aeromedical transport of acutely ill patients and it was shortly after his return to UK that his tragic death occurred.

As well as being a doctor and Naval Officer there were many other facets to Dave. Always a naturally quiet and private person he had a sensitivity that in later years often went unnoticed under his tough action man persona. It was this sensitivity I suspect that made him such a caring doctor and gained him such a large number of loyal friends from all spheres of his life. Dave was sensitive but he was also remarkably tough both physically and mentally as his partners from the score of gruelling mountain marathons he has completed will testify. Dave's love of the outdoors was fostered from an early age partly by like-minded big brothers, partly by the CCF and more latterly at university where he was an active member of the mountaineering and orienteering clubs. He also enjoyed skiing

[illegible] suggested
was [illegible] in particular [illegible]
He [illegible] with enthusiastic to explore
crew [illegible] would pore over maps for the
coast [illegible] routes to ride. The latter
was [illegible] horrible story though because he
enjoyed [illegible] riding his bike almost as much
as [illegible]. He loved being up to his elbows
grease [illegible] stripped down and rebuilt
paying [illegible] attention to the smallest
[illegible] detail.

[illegible] sports though Dave's personal
pas[illegible] of late back seared his demanding
job and [illegible] family life. He met Jo Anne in 2001
whilst they were both working in Plymouth.
They set [illegible] home together in Edinburgh
during Dave's specialist training and were
married in 2003. He [illegible] as really took

respons b ty [illegible] was co mplet [illegible] son Benja [illegible] ty fam ly and I [illegible] them all a d [illegible] memorabe v [illegible] beautiful Abe T [illegible] by e traditional [illegible] Christchurch expertly cooked by Dav [illegible] o the barbeque Th s was the last t me I was to see him as I was deployed to Afghanistan when he returned to the UK

Aga nst this backdrop of viv d memor es of Dave many of us are still struggling to make sense of his tragically premature death It will be a constant source of sorrow to those of us w o loved h m that n his darkest hours we co ld not help h m but perhaps we can take so ace n the thought that he s at peace now ree from whatever demons were tormenting h m L fe w thout Dav d is hard to contemplate a d e w ll be much missed by his fam ly friends and colleagues He leaves behind his brothers Michael Matthew Jonathan Andrew and Peter his parents June and John his w fe Jo son Ban and step children Liam and Amy all of whom rema n n our thoughts and prayers

by Surgeon Capta n Andrew Hughes MBChB MRCGP Royal Navy

Notice has been received of the deaths of the following

Surgeon Rear Admiral Harry Russell Mallows

Surgeon Captain Ronald Stewart McDonald OBE Royal Navy

Surgeon Captain Murdoch Assynt McLeod Royal Navy

Surgeon Commander J A Bakhai Royal Navy

Surgeon Lieutenant Commander D J Hughes Royal Navy

The editor would welcome any words in memory of them

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The title page should contain a concise and informative title, the names and initials of all authors, the author's rank/rate, and the name(s) and address(es) of the department(s) and establishment(s) where the work was carried out.

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Tables and illustrations (figures) should add to the paper rather than only repeating information presented in the text. Each table and illustration should be on an individual page separate from the text, be numbered in two distinct sequences in the order in which they are mentioned in the text, and have an explanatory caption (typed on a separate sheet for illustrations).

News photographs of academic, social, sport or other occasions involving members of the Royal Naval Medical Service are welcomed.

Normally, printed illustrations will be monochrome. The views of the Editor should be sought where colour illustrations are thought to be essential or highly desirable. Photographs must be of good quality, glossy and mounted, and be provided in camera-ready form, with redundant areas trimmed off. The figure number, author's name and top/bottom of figure must be marked on the back. Line drawings should be professionally drawn and labelled or lettered, and submitted as good quality originals or high quality photographic prints. Lettering should be of a size to ensure legibility after reduction for publication. Freehand lettering is not acceptable.

Measurements and abbreviations

Measurements should be given in the units in which they were made, but with the exception of blood pressure in mmHg and haemoglobin concentration in g/dl, non-metric units must be accompanied by metric (SI) equivalents. The approved name of drugs should be used (proprietary names may follow in parentheses). If an abbreviation is used, the term for which it stands should be given in full at first mention in the text, e.g. Institute of Naval Medicine (INM).

References

Responsibility for the accuracy and completeness of references lies with the author(s) and these will not be checked by editorial staff. Only essential references should be included, and authors should verify them against the original documents. References are identified in the text by superscript Arabic numerals and are numbered and listed consecutively at the end of the manuscript in the order in which they are first cited in the text. A full list of references should be given at the end of the paper using the form of reference adopted by Index Medicus. Papers accepted but not yet

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Contents

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Editorial

This edition of the Journal carries an assortment of contributions that will appeal some way to all our readers. For those whose interests lie in the early years of the Service there are two fascinating papers. The first, a written version of the year [illegible] Lecture links the involvement of the Worshipful Company of Barbers with the Royal Naval Medical Service and the selection of holders of that post who might be considered to be contributors to a theory and the wider practice of naval medicine. It was observed after the lecture that naval surgeons were frequently criticised for their lack of medicine over and above the ability to read, write and [illegible] Charged to keep it with what the 52nd Regiment General Duties Medical Officer [illegible] described today is like comparing chalk and cheese. But [illegible] underlying [illegible] the knowledge, skills, opinion and [illegible] of naval surgeons [illegible] were most imaginative naval surgeons of the 18th and 19th centuries [illegible] important to comprehend. Each in their own words and [illegible] equally [illegible] health of the sailor and the command of [illegible].

The second paper gives an [illegible] of the [illegible] people involved through [illegible] to [illegible] exercised the naval surgeon [illegible] recorded though the [illegible] investigation and advancement [illegible] and physicians were [illegible] the conditions under which [illegible] recorded through the correspondence [illegible] historians of the future will have [illegible] doctors net and elsewhere and what [illegible]

These papers also [illegible] role in the life of the naval surgeon [illegible] for our doctors of the 21st [illegible] undoubtedly express the [illegible] professional development [illegible] has not been quite such a disaster [illegible] military trainees involved in the [illegible] evidence to dispel any feelings that [illegible] every individuals expectations [illegible] laden newspaper columns [illegible] now have hard evidence of the full [illegible] relatively constrained horizons [illegible] recommendations so eloquently [illegible] consideration by the Defence Medical [illegible] Branch Managers. Yet again we [illegible] external events even as we [illegible] environment.

[1] Teske J et al. *Aspiring to Excellence* [illegible]

T [illegible] r ou n greater detai l n the Med cal
[illegible] n Red Dinner It s clear that the
[illegible] tar removed from that of today
[illegible] y s organ sat on are pla n to see
[illegible] g and responsive to chang ng
[illegible] any reorgan sation and u do u ly
[illegible] al ke The staccato sequence
[illegible] v ed cal Serv ces have bee suhje t
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[illegible] and that the cu va strap line the Team Works encapsulates those
[illegible] cpts most appropr ate

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General

Serjeant-Surgeons, the Barber-Surgeons' Company and the Navy

Sir Barry Jackson

Based on The Charles Bernard Lecture given at The Institute of Naval Medicine on 31st May 2007

In a prominent location in Barber Surgeons' Hall there hangs a portrait in oils of Charles Bernard (Fig 1). Painted by Thomas Murray a Scottish portraitist in 1711 it was commissioned by the Company at the time of Bernard's death and cost the then princely sum of £12 10s. The Latin inscription below the portrait translates:

> *The Company had this portrait painted of Charles Bernard principal surgeon to The Queen. He was an excellent Greek and Latin scholar a highly skilled surgeon with a frank and honest disposition. His abilities were greatly valued by the Most Serene Queen Anne. He enjoyed an outstanding reputation among both friends and strangers. He owned a library of almost a thousand books. This commemorates his outstanding service to the Most Serene Queen to the Exchequer and his other distinguished services to the community of surgeons.*

Clearly he was an important person in his day and it is fitting that this lecture should perpetuate after him.

The frame is unusual in that the ornamentation consists of real scallop shells underneath the gilding and it has been suggested that these reflect Bernard's association with the Royal Navy. I doubt that this is true however because his coat of arms is designed before he had any association with the Navy shows scallop shells as a prominent feature. It is likely that the frame maker merely incorporated this feature of his armorial bearing

Royal Operations

and fo [illegible] him wh d has subs [illegible] and the [illegible]

Sadly no [illegible] royal surgeon [illegible] Company [illegible] with the Navy [illegible] have been ma [illegible] Company co [illegible] naval connect [illegible] perhaps less we [illegible]

Before 1540

An early royal s [illegible] rode with Henry V [illegible] was influential in th [illegible] same Gild that [illegible] the Company of Bar [illegible] the Company s a [illegible] of the Gild written abou [illegible] leather bound parchment [illegible] oldest Company posse [illegible] Charter of 1462. Although [illegible] before the manuscript [illegible] was responsible to [illegible] developing the orig [illegible] and the Company's cu [illegible] from his work. He is [illegible] figure in the history of the Com [illegible] some claim him to be [illegible] Surgeon although th [illegible] ascribed to William H [illegible]

Hobbys was not [illegible] was also the Royal [illegible] Doctor of the King's [illegible] medicine, being a Bachelor [illegible] Oxford and having a D [illegible] from Cambridge. Alth [illegible] Warden of the Barbers [illegible] became Master. In h [illegible] silver cup to the Barber [illegible] the Gild of Surgeons [illegible] expected some [illegible] the foremost s [illegible]

The United Company of Barbers and Surgeons of London

We run on now to 1540 [illegible] the Barber Surgeons' Co [illegible] that existed for a [illegible]

[illegible]

William Clowes (the Younger and the Elder)

William Clowes was admitted to [illegible] of the Company in 1605 and promoted Liveryman in 1615. He was appointed Serjeant Surgeon in 1625 and Master [illegible] following year. But he had no navy connection; he was an extraordinary [illegible] man and he was surgically und [illegible] When he was elected Master the [illegible] some memoirs of the Court who [illegible] ore to him because of his unpop [illegible] may wonder why I mention a [illegible] distinguished difficult man who [illegible] navy connection. The answer [illegible] son of William Clowes! [illegible]

[illegible]

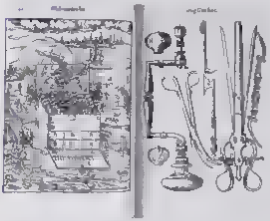

Fig. The surgeon's chest and surgical instruments from A Portable and Necessarie Booke of Observations By William Clowes 1596

His most famed book A Profitable and Necessarie Booke of Observations went through several editions and developed his stories of patients he had met during his naval career. It was a well known illustrated text of a compendium of the then current knowledge of surgical procedures and techniques (Fig ?) Showing some of the instruments used in the sixteenth century and there fore fascinating for the skills and skilled trepanners as well as awesome looking and pleasantly early form of dentistry. The book was printed in black letter type as all the medical and English which was current at the time. Most medical [illegible] published Latin and Clowes

[illegible] originally criticised by some of his colleagues for publishing a book in English which could be read by any of the people who were literate. It was believed that Latin texts could be written in Latin the ordinary man or woman could not [illegible] to the profession [illegible] Edict of the plague in 1604 [illegible] which prohibited medicine as an [illegible] science or practical evaluation history

John Knight

John Knight had a long life of 80 years 1600 1680 but he is unusual in that for his first 39 years he had no connection of any kind with medicine or surgery. Until he approached forty he was a practising Anglican clergyman. Then for reasons unknown he changed his vocation and came to London to be apprenticed to one of the surgeons at St Thomas's Hospital Edward Molins. After his apprenticeship he became a military surgeon and sailed with the Prince of Wales (later Charles II) in an attempt to seize the Scilly Islands. Unfortunately he was captured but soon escaped first to Jersey with the Prince and the exiled court and then to Europe where he remained in exile for several years. He returned to Britain at the time of the Restoration in 1660. The following year he was appointed Sergeant Surgeon and in 1663 Master of the Company (a post he held again in 1669 and 1677). In 1676 by the King's mandate he was made a Lieutenant of the Royal College of Physicians. Towards the end of his life he arranged the burial of the skeletons of the two Princes found in the Tower of London.

John Knight was learned and widely read. Among other interests he was knowledgeable about antiquities topography and heraldry. He had a magnificent library of books many of which he bequeathed to Samuel Pepys a close friend.

In 1664 he had been appointed Surgeon General of all forces and as a consequence became closely involved with both the second and third Anglo Dutch Wars. At that time senior military medical men very often had duties with both the Army and with the Navy

and they moved between one service and the other as necessary Knight all ed h mself especially closely w th the Navy although he also had Army duties from t me to t me He was present at the Battle of Lowestoft n 1665 during the second Anglo Dutch War In his capacity es sen or surgeon w th n the Navy he was responsible for tr age of the injured arranging for disembarkal o r of the large number of injured sailors and their d spersal to various hosp tals especially St Thomas s end St Bartholomew s n London On one day alone t rs recorded that 52 injured sailors were adm tted to St Thomas s the hosp tal where Kn ght had undertaken much of h s medical tra n no

Dur ng the th rd Anglo Dutch War in 1672 he was present at the Battle of Solebay and again was responsible for t rage of the wounded There were some 800 listed casualt es of that battle and many additional bodies and parts of bod es were washed up on the beach n the ensu ng weeks

The leader of the English forces was Adm ral Sandw ch who sadly was k lled Knight was dismayed to f nd that the Adm ral the sen or naval offcer had been embalmed by a Reg mental Naval Surgeon rather then by himself for he believed that as Serjeant Surgeon he should have been responsible for th s task After all the Serjeant Surgeon was responsible for embalming the King

John Kn ght rs someone w th special affiliations to the present Barbers Company because the Company owns treasures that have a Knight assoc ation A shagreen surg cal nstrument case w th Kn ght s m trials n silver on the l d has been in the possession of the Company for many years and s on d splay in Barber Surgeons Hall The contents have long since d sappeared but the case almost certa nly belonged to Kn ght and would have been carried w th him at the various conf cts he attended The silver-g lt Grace Cup presented to the Company by Henry VIII was restored and repa red dur ng the Mastership of Kn ght and ns de the l d there s an nscr pt on recording th s fact The Royal Oak Cup was presented to the Company by Charles II n 1677 at the t me of Knight s third term as Master and has Kn gh[illegible] one of the panels The [illegible] escape of Charles II afte[illegible] Worcester ar Boscobel H[illegible] h d n en oek tree o e [illegible]

Richard Wiseman

A contemporary o John Kn ght [illegible] W seman Master of the [illegible] and appointed Ser eant S g[illegible] Although often known as a [illegible] most of h s w r ngs rea[illegible] as a naval surgeon rat[illegible] w th both Forces He [illegible] surgeon n the Civ l Wa[illegible] went into exile w th the [illegible] of Wales He returned to England in 165[illegible] continued n serv ce with the Prince Af[illegible] Charles had been crowned n Edinburgh 1651 as King of Scots his troops moved to end at the Battle of Worcester Charles was defeated by Cromwell s forces Wiseman was captured and mpr soned for several months Chester geol After release he came to London and desp te being e Royalist was allowed to set up prem ses as a su geon n the Old Ba ley where he established e l ve pract ce Unfortunately one of his pat ents who was mpr soned n the Tower of Lo don escaped and W seman was thought probably wrongly to have enabled the escape He was arrested once aga n and mpr soned n Lambeth Palace for several months

After release he jo ned the Navy No r c Royal Navy but the Spanish Navy He serv ed with the Spanish n Dunk rk Spa n and Br t sh West Indies over a per od of more than three years and his experiences during that time enabled h m in later life to w te what most author t es bel eve to be the most important seventeenth century text book of surgery

The year he became Master of the Company 1665 was the year of the Great Plague in London He was then aged only 44 one of the youngest Masters to be elected He left London to escape the plague and went to the North of England Sadly the Minute books of the Company for that per od were destroyed the follow ng year n the Great Fire and so t s unknown how many meetings of

[illegible]

Charles Bernard

And so we come to Cha[illegible]

question about him which remains more research Why is he one of the lesser known surgical history In order to see an Knight and Clowes the Elizabethan era surgeons singled out Sedgwick Bernard has never been the subject of a full biography and his name rarely appears in standard books on the history of surgery suggest the answer to this mystery is that he wrote no books and very few scientific papers of the day kept his name alive while the profession The solitary publication been able to trace is a communication *Philosophical Transactions* 1685 the excision of two adjacent urethra of a male patient On paper was read to the Royal elected a Fellow on the nomination Sloane Would that election Society was as easy today The history of both the Company which is rightly regarded as a key figure hence the founding

Apart from his portrait the present day Barbers important and valuable tenure forever will be associated with name Through his friendship monarch Queen Anne Serjeant Surgeon he arranged should present to the Barber Company a large wine cup referred to as a punch bowl It reads *To the Society of Surgeons in consideration of their free in examining Surgeon to the Navy the most Serene Queen Princess presented it Charles Bernard Esquire Principal the Queen Master of this Society at his prayer* This recognition attention to the important Company in the professional naval surgeons a role that for many years before Anne and one in which Bernard patronised

The origins of the examination

surgeons by the sixteenth century Royal College Board of 1606 it they were to

The Medical Household today

And so to today What of the Serjeant in 2007? The medical Royal Household in London (there is another Household in Scotland) comprises a Physician to The Queen who also is the Head of the Medical Household a Physician to the Household a Serjeant Surgeon to The Queen (currently a Yeoman of the Company) a Surgeon Queen (currently a Freeman of the Company) a Surgeon to the Household In addition there are a Surgeon Gynaecologist a Surgeon Ophthalmologist a Surgeon Dentist and in also the very tandoori fashioned term for a General Practitioner) all these appointments to The Queen There is also a Medical

RCS FRCP

J Royal Naval Medical Serv ce 2007 93 3 109 114

General

Doing it by the book: what the libraries of the Royal Naval Hospitals can tell us about naval medicine in the nineteenth century

Jane Wickenden

Introduction

The H storc Collect ons at the Instit te of Naval Med cine cons st of the an alg ma e nt collections of the former Royal Naval H sp tal l braries at Haslar and Plymouth da ng from 1827 and 1832 respectively housed at INM since the late 1990s A very few books have reached the collections from Greenw ch Chatham and Royal Naval Hospitals abroad

The history of the libraries

The museum and l brary at Haslar were opened in 1827 and at Plymouth in 1832 Two years later the Instructions for the Royal Naval Hosp tals were updated accordingly (1) The appropriate page ahead of the Book for Da ly Issues of Wine and Porter and the Statement of Linen sent to be Washed is headed *"Instructions for the Librar an and lecture*

The l brarian s duties as with many a l brarian before and since stretched well beyond books Tasks included *a course of lectures twice in the year on the practice of Medicine and Surgery as far as the same may be more part cularly applicable to the diseases which are prevalant an ongst Seamen"* Addit onal lectures were expected on physiology pathology and pharmacology and the l brarian also had to carry out weathe observat ons for which *the p aper philosophical instruments* were prov ded The Librarian in those days was also to be present at operations in the hosp tal n order to take his pick of removed body parts the present librar an sincerely hopes that th s instruct on w ll not be revived

The l brarian had no control over the b dget wh ch for 1836 comprised £100 pe r m for both ave ed p t l l br e T h A l bo k of so standard b ks a a d t Med c l Cl ss Nav l H sp t l Vad m Exam ne P ss s s l Ph s c n of Nav l de m p l b y n b n ex m n t n pl ts h d n t n n t l c tes n j d qu began only)

As t l A l t n N v l H sp t l l b y m ll a pr pe

The life of a naval surgeon 1827 1871

Much emph s l t least was placed on th o l theoretical knowledge l u pp nent however that nava o l s so much medic ne t l n n st ggled w th the appl c t o l g n l l the practica l n th l Ass st s bo d s l to learn as well as why wh d co d o s some d scourt l v l n l w volumes n th stud co 2 com p l d by S n n o n Pu n the 1930s ro s l L t

A lec n by t m d l o ass stant s c l y n one of th r number t c t l y at studying d t l th c unrecognised c t Th t n would be y y n p t t o comprehe udy d t pr ss s v l b w

number to 473. Alexander Bryson, who had died two years before, Brown's book was published, would not have been impressed.

Alexander Bryson 1802–1869

At this point Bryson's career should be considered in more detail for his reputation is or what it should be. The Oxford Dictionary of National Biography's article on him unfortunately perpetuates the unrelentingly dismissive tone of his Lancet obituary stating that he was to be *interested more in statistics than in the problems of naval medical officers* (7).

By coincidence, Bryson entered the navy in 1827, the year that Haslar opened its library. To understand the reason for his most important single work, *Report on the climate and principal diseases of the African station*, we must also appreciate a major theatre of naval medical experience in the nineteenth century.

Although the slave trade was abolished in 1807 and illegal in most nations, it continued on a large scale illicitly until 1865. The Royal Navy's West Africa station was established to suppress it. Its successes, *Report* details, were much from its [illegible] was not merely [illegible] allied to the lost [illegible] and dual healthy se[illegible] of Bryson, officers and [illegible] Tr[illegible] edge and little [illegible] [illegible]

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Sidney Bernard Boa Vista, and the fate of HMS ECLAIR

HMS Eclair arrived in Freetown in February 1845 (8 9) In Apr the first case of yellow fever occurred The ship sailed again in July and by the time she arrived at Boa Vista in the Cap Verd Islands in August sixteen men had been lost to fever A month later she sailed for Madeira 39 crew had died including the assistant surgeon At Madeira they were refused permission to land the ship's captain and two remaining medical staff had also died Sidney Bernard assistant surgeon on *HMS Rolla*, who had been returning to England offered his services and sailed as surgeon with the *Eclair* late in September A further 17 members of crew died before they reached England The Principal Medical Officer of Hasl
Hospital was willing to take the crew ashore but Sir William Pym Superintendent Ge a
Quarantine insisted that he ship proceed to the Quarantine Station at Stangate Cree
besides Burntwick Island in the Medway where she arrived on 2nd October Next day ve
more men died and Sidney Bernard himself fell ill He died on the 9th October 1845

The Health of the Navy

In the
2) quote
Healt

1860s.

The naval medical service in the Crimea

Given the [illegible] Army's statistical [illegible] into the health of the Navy in the Crimea [illegible] 1860s.

Surgeon, scientist, naturalist, explorer

The indefatigable Frederick Brown quoted earlier (6), who over twenty years later was a FRCS and still writing about the naval medical service, was a mere assistant surgeon when he sent round a questionnaire on ships' hygiene. No doubt much to the exasperation of surgeons and captains alike. The results were written up in his *Questions and observations on hygiene* published in 1849 (15).

Mr Brown had a dream. *When naval medical gentlemen receive the liberal and scientific education there will be physiologists and chemists of the first order among them as well as naturalists and I trust that those who are capable of microscopic and analytical examinations will be permitted to reside on shore at the expense of Government for the purpose of instituting experiments. In this manner laboratories and microscopic objects would be erected in every corner of the world as used by British men of war.*

This passage and the earlier mention of books to be purchased for the libraries serves to illustrate the wide range of interests that were required reading for naval surgeons. Precisely because they so often doubled as ships' scientists on exploratory surveys, every voyager bound for uncharted territories and ethnological studies left home with a list. The libraries at the naval hospitals were collectively hell-bent on collecting the present compendiums of the history of nations, either with titles such as Gould's *British Birds* (16) to which Hooker's *Flora Antarctica* (17) and Darwin's *Beagle* Reports had [illegible]

All the books in the library most of them have bear they show few signs of copy presumably a working Dallas's *A natural history* kingdom published in Lo around 1856 (18) Th include notes on the fe Chilean names of birds a photograph of Thomas He h mae provides a cla more unusual type of naval

He joined the Navy h s s nent debts and was n in *HMS Rattlesnake* to New G duties in the Torres Stra He illust subsequent *Narrative of the voyage Rattlesnake* (19) and rather later due reluctance of the Admiralty to fund t published *The ocean c Hydrozoa a des of the Calycophondae and Physopt observed during the voyage of H M S "Rattlesnake"* in the years 1846 1850 (?0) T Historic Collections Library now holds both files Eventually Huxley resigned from t Navy to pursue his research or tion he Tordship's point of view was struck off the refusing to join *HMS Illustrious* at Portsmouth in 1854 (3)

Will Maillard, 1863-1903 V C R N M D

Another perhaps less maverick but still unqu naval surgeon from the very end of the century concludes this paper W J (Will) Maillard was of the staff of Haslar in 1889 As s evident from a photograph in an album now in the Historic Collections The story of his Victoria Cross award may be read elsewhere (21) but included here are a few quotations from his letters of September 1898 He evidently had something of a sense of humour

Good heavens it was a narrow squeak I was wondering how I should die whether [they] would shoot me or burn me pi stab me I was quite unarmed the whole time I thought a revolver would only be in the way – and I might shoot myself or one of our fellows (22)

And I cannot believe that I have been recommended for the VC (though I has always been one of my secret ambitions) In all

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11 Anon *Report of the Committee of Council on Education* [illegible]
12 Anon *Medical Officers' Reports* [illegible]
13 Anon *Letters from the Crimea* [illegible]

Acknowledgements
This paper was originally presented in a different form at the *Security* conference Army Medical Service [illegible] 13th April 2007 Thanks are due to [illegible] organisers and conference organisers [illegible] Starling for permission to publish [illegible] Surg Capt (retd) John Carney RN [illegible] with Powerpoint

General

The truth about MTAS...

N S Bevan

Elsewhere in this section Captain Colonel J Owen (1) evaluates the feedback received from DMS Medical Officers who applied for entry into Specialty Training (ST) during 2007 using the Medical Training Application Service (MTAS). This feedback was obtained through a questionnaire sent to all DMS MTAS applicants and although the response rate was disappointingly low enough completed questionnaires were received to indicate the general feelings of DMS applicants about MTAS which came across as negative when those of most of their civilian colleagues

This was surprising given that the greatest anxiety of their civilian colleagues was generated by some inadequacies in the long/short listing procedures and the fact that a significant number were not actively offered an interview during the first round. No such anxiety should have arisen for DMS applicants as all were appropriately shortlisted (long listing was not relevant in our case as all DMS applicants already met the standard criteria to eligibility to apply) and all were offered an interview in collaboration with the West Midlands Deanery (WMD). Furthermore they were aware that if they were successful at interview sufficient training capacity existed in most specialties within the DMS so that the majority would be offered a training programme with choice of location linked to their level of success – ultimately 80% were offered a Run Through (RT) Training Programme and a further 8% a Fixed Term Specialty Training Appointment (FTSTA).

So why the dissatisfaction? All questionnaire responses were received before any MTAS results were known so there could have been no bias related to the result. Clearly there was genuine concern among DMS applicants that the MTAS process was lacking

[redacted]

[redacted] total 13600 [redacted] accepted [redacted] 1 Aug 07 [redacted] and went [redacted] yes [redacted] was a chaotic day for many [redacted] but they coped (and in many cases the [redacted] resJay August has always been [redacted] Trust st The e will tell exactly how [redacted] ures will remain placed by Nov [redacted] ven that t will be nothing like the [redacted] ed by an hysterical media earlier [redacted] ever know what would have [redacted] r c g al timetable had been [redacted] ns Round 2 would have [redacted] e Aug 07 s art and t e possible [redacted] not have been much [redacted] e r ll have the same [redacted] n, add only a slight increase [redacted] p r t r t o the review [redacted] s? Al 162 applicants [redacted] er owed by mid Jun 07. One [redacted] thirty one successfully [redacted] ed against their civilian colleagues [redacted] offered RT programmes the vast [redacted] y in the specialty or their choice [redacted] who were borderline ar nterview were [redacted] TSTAs giving them an opportunity to [redacted] ed in rer training and to improve their [redacted] ts or MTAS 08. Eighteen applicants [redacted] y failed to benchmark n either their [redacted] u choice (only a few requested a 2nd [redacted] re view) but nevertheless have been [redacted] r t a n ng posts n the clinical [redacted] vironment of their choice again giving [redacted] a opportunity to improve their prospects r [redacted] r year. However 5 out of 13 FTSTA [redacted] o rees and 14 out of 18 non [redacted] benchmarkers were applicants for surgic [redacted] al es n which dr general surgery spa [redacted] ty S currently has limited training capacity [redacted] ope on will remain fierce again next yea [redacted] So was the ST selection process in 20[redacted] n for purpose for the DMS? Clearly t [redacted] f n perfections as the 21 surgical [redacted] d ants who normally failed to be ranked h [redacted] ave op nd neq uivocally. The 36 surgical [redacted] (all surgical specialties including [redacted] FAs who were successful have been [redacted] ed to commitment. Across all specialt [redacted] success rate even for surgical spacialties [redacted] excellent compared with other Deaneries w [redacted] can be proud of our performance and particularly that of a number of individuals who were truly outstanding.

And next year? The development of the application and selection process for ST n 2008 is already underway and a number of new proposals are being considered. It seems likely that an online application system will still be used possibly still called 'MTAS' but hopefully with improved technology and used only for ll c management of applications the selection process is likely to remain local to Deaneries once more. Within the DMS we will continue to require our applicants for ST to benchmark against their civilian colleagues with in the WMD and we will work to ensure that any app opriate military experience gains due recognition. A full final report of the Tooke review is not expected until Jan 08 any recommendations from this which should shape the definitive model for MMC cannot be implemented until 2009 this should allow time for a more measured approach and greater consultation with the Royal Colleges and the profession as a whole.

Reference

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[redacted] do e N S BELAN OHP OS J FRCGP FHEA RN *Defence Postgraduate Medical Dean*

General

An Evaluation of the Medical Training Application Service as experienced by Defence Medical Service Medical Officers

J P Owen

Abstract

Objectives In 2007 Defence Medical Service (DMS) Medical Officers (MOs) [illegible] with non hospital based specialties were selected using the Medical Training Application Service (MTAS). Recognising the [illegible] being reported about MTAS, the Defence Postgraduate Medical Deanery [illegible] conducted an evaluation [illegible] whether DMS MOs had also [illegible] problems with the MTAS process.

Methods DMS MO applicants [illegible] email questionnaire [illegible] (Likert scale) and narrative [illegible] their opinion about the application [illegible] questionnaire covered the [illegible] of the process, the support available and the ability to demonstrate appropriate [illegible] and skills.

Results Only 42 responses [illegible] received. However having considered [illegible] potential bias, the graded [illegible] and thematic analysis of the narrative responses showed a clear consensus [illegible] applicants in many areas. More than three quarters (78%) of DMS applicants [illegible] opportunity to record their [illegible] achievements, and 91% [illegible] questions were unable to [illegible] candidates. These views were [illegible] narrative responses [illegible] statements covering five topics [illegible] areas for improvement. Strong [illegible] recorded for the work [illegible] DPMD in support of the candidates.

Conclusions DMS MOs [illegible] negative opinions of the [illegible] MTAS, highlighting [illegible] were unable to record [illegible] experiences and that [illegible] unable to discriminate between [illegible]. Particular difficulties [illegible] presenting non NHS experience [illegible]

Background

The Medical Training Application [illegible] [illegible]

Methodology

In order to gauge opinion [illegible] introducing outcome [illegible] conduct the evaluation [illegible] between completion of [illegible] and dissemination of the [illegible] based questionnaire approach [illegible] order to assess a dispersed [illegible] enable rapid data collection.

A five point Likert rating scale [illegible] questionnaire was used to gauge [illegible] within the three areas. Firstly, the [illegible] process and procedural aspects involved [illegible] accessing and completing the MTAS [illegible]; secondly, the quality of support [illegible] individual that was available from Royal Colleges, Defence Consultant Advisers (DCAs), DPMD and MTAS help desks; and thirdly [illegible] [illegible] and effectiveness of the application [illegible] [illegible] questions in a [illegible] section. A [illegible] section was also provided for a small [illegible] [illegible] to enable more free [illegible] [illegible] expressed covering two areas [illegible] aspects of the application process that [illegible] and those which could be improved [illegible] analysis was carried out to [illegible] of opinion [illegible] [illegible] to examine the [illegible] [illegible] [illegible] [illegible] compared to [illegible] [illegible] [illegible] [illegible]

The questionnaire was distributed via e-mail [illegible] a covering letter [illegible] questionnaire [illegible] voluntary [illegible] [illegible] [illegible] [illegible] [illegible] the question [illegible] [illegible] [illegible] [illegible] paper [illegible] [illegible] [illegible] [illegible]

Results

One hundred and [illegible] DMS [illegible] who had gone through the MTAS [illegible] procedure for entry into hospital disciplines at ST1, ST2 or ST3 were contacted by email from the database held within DPMD. A total of 42 (32%) personnel responded (35 using email and 7 using paper responses). The Service mix was Navy – 21%, Army – 57%, RAF – 21%, with 88% Male and 12% Female respondents. The specialties applied for were Surgery (52%), Emergency Medicine & Acute Care Common Stem (19%), Anaesthetics (19%), Medicine (10%).

Table 1 [illegible]

	Grouping	Questionnaire Responders Profile	Total Target Group Profile
Service	RN	9 (21%)	[illegible]
	Army	24 (57%)	[illegible]
	RAF	9 (21%)	[illegible]
Gender	Male	37 (88%)	[illegible]
	Female	5 (12%)	[illegible]
Medical Specialty	Anaesthetics	8 (19%)	[illegible]
	Emergency	8 (19%)	[illegible]
	Medicine		
	Medicine	4 (10%)	[illegible]
	Surgery	22 (52%)	[illegible]
	Other	9 (8%)	[illegible]

The responder population was compared with the total DMS applicant population in order to identify potential sources of bias (Table 1). No significant difference was seen in the Service profile or the ST application year of the responders compared to the total group. There were however some differences between individual specialties, with an over representation of surgical (Chi Square Test, Surgery vs Non Surgery Ratio, p = 0.025) and under representation of anaesthetics applicants (Chi Square Test, Anaesthetics vs Non Anaesthetics Ratio, p = 0.028). It should be noted that this equates to a single applicant difference in each group due to the relatively small numbers involved. Whilst [illegible] of the responder group [illegible] [illegible] the MTAS success rate for DMS MOs as a whole has been very high [illegible] ranging from 100% passes for [illegible] and 97% [illegible] Anaesthetics [illegible] to Surgery (including all surgical [illegible]) [illegible] [illegible] of the [illegible] [illegible] group [illegible] [illegible] [illegible] surgical group.

analysis was conducted on the Likert responses to compare Surgery vs Non-Surgery responses and is noted when a significant difference was detected.

Table 2 Assessing the technical aspects of the application system

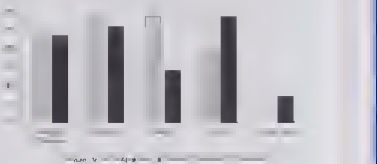
Questions re Statement	Mode & (% of total)
Statement: the application system was easy to use	4 (45%)
I was able to access and navigate through the application system as desired	4 (45%)
I was able to save and exit the application form as required	4 (31%)
The application system was an appropriate way for me to complete my application	2 (29%)
The training how to operate the application system was adequate/relevant for me	3 (45%)
The system was timescale for completing my application was sufficient	4 (29%)
Overall, how long did it take you to complete and submit your application	31 hrs (Mean)

Key to Descriptors

Strongly Disagree 2 Disagree 3 Neither Agree nor Disagree 4 Agree 5 Strongly Agree

Technical Aspects of Accessing and Completing the MTAS Forms The modal values for the responses indicate that the candidates were able to access, navigate and use the on-line application system with ease (Table 2). When considering whether the online system was an appropriate method for applying, more than half responders (53%) disagreed or strongly disagreed, with only 19% agreeing to any degree. Whilst the potential value of applicants reported that they would find the timescale of 'within the last 120 days' the overall response was more negative (Mode = Disagree, Strongly Disagree = 29% versus Agree = 29%). When assessing the process of using the application system, the majority had experienced difficulties, a minority had experienced no difficulties. The experiences [illegible] with the majority [illegible] 57% experiencing minor difficulties.

Figure 1 Application System



Availability of Information The responses for this section were [illegible] negative for all components except [illegible] 3). None of the MMC/MTAS about information were considered [illegible] 62% having negative responses [illegible] MMC/MTAS applicants guide and 60% reporting that the MMC web site was useful. Even more marked responses were seen when considering the usefulness of MTAS web based help with nearly three quarters (74%) of responders having a negative opinion of its usefulness (Figure 2). The only aspect rated positively was the advice provided by the Defence Consultant Advisers (DCAs) (43%) although even this showed a broad spread with only slightly fewer negative responses overall (34%) (Figure 3).

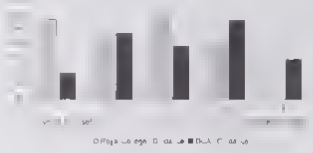
Table 3 Availability of information when completing the application [illegible]

[illegible]	Extent of Use Mode & (% of total)	Usefulness Mode & (% of total)
[illegible] MMC/MTAS	3 (35%)	2 (36%)
[illegible] MACP/TAS web site	2 (28%)	1 (33%)
[illegible] MACP/TAS web site	3 (28%)	2 (34%)
MTAS [illegible]	1 (28%)	1 (48%)
[illegible]	3 (33%)	2 (21%)
MMC website	3 (48%)	1 (38%)
[illegible] DCA [illegible]	4 (26%)	4 (29%)

[illegible] ◄ ► 5 Used a Great Deal

[illegible] ◄ ► 5 Extremely Useful

Figure 3 G ... Royal Colleges & DCs



... Royal Colleges ... DCs

Satisfaction with Advice Provided There was a marked contrast in satisfaction with advice provided by the MTAS/MMC help-desks and that from DPMD. With two thirds (67%) of applicants stating that they were satisfied with DPMD and only 17% expressing dissatisfaction whilst the opposite was shown for the MTAS/MMC help desk with only 5% positive responses and 69% negative (Figure 4).

Figure 4 Helpful Advice Ratings (DPMD & MTAS/MMC Helpdesk)

... DPMD ... MTAS/MMC Help Desk

Figure 5 Selection Criteria Questions (Relevance & Appropriateness)

... Relevance ... Appropriateness

... Score for the application form

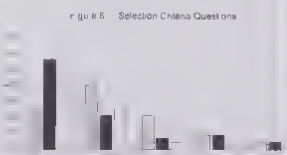
Questionnaire statement	Median (% of total)
... Selection and personal knowledge	5 (83%)
... entry criteria sections of the application ... number of hoops applicants was applying	3 (58%)
... entry criteria sections of the application ...	4 (83%)
... selection criteria ... were relevant ... was applying for	2 (50%)
... selection criteria questions asked ... the entry criteria	2 (58%)
The competency selection criteria questions appeared to be fair	2 (42%)
The selection criteria questions gave me sufficient opportunity to record my abilities and achievements	1 (67%)
The selection criteria questions were sufficiently detailed to differentiate between candidates	1 (100%)
How long did it take you to complete the application form questions?	2 (6 hrs)

Rating Descriptors

Strongly Disagree 2 Disagree 3 Neither Agree nor Disagree 4 Agree Strongly Agree

Content of the Application Form There was broad agreement that the entry criteria questions were relevant and fair however when considering the selection criteria questions there was significantly more disagreement (Table 4). Nearly three quarters (72%) of the responders thought the selection criteria questions to be irrelevant and more than half (60%) thought the questions inappropriate for their specialty (Figure 5). Even more polarised views were expressed in the remaining areas with 64% regarding the selection questions as being unfair. More than three quarters (78%) did not think that they had sufficient opportunity to record their abilities and achievements and crucially 91% recorded that they did not think that the

Figure 5 Selection Criteria Questions



... Relevance ... Appropriateness

questions were able to differentiate between candidates (Figure 6). This last comparison also revealed a statistical difference between sub-groups (Chi Squared $p < 0.001$) with 85% negative response from surgical applicants and 94% negative response from non surgical ones.

Narrative Evaluation. The narrative were read with the responses being grouped into themes. These were then compared to the statistics read independently adding subjective insight to themes if appropriate. The revised data was collated and consolidated into the set of broad themes with sub-topics as summarised below.

'What Went Well'

Themes	Sub Topics
General Supportive Statements	
IT Elements	On line application system Application form
DPMD & DMS Specific Issues	DPMD general support Communication & information flow from DPMD Defence Consultant Advisers

'Areas For Improvement'

Themes	Topics
General Dissatisfaction	Confusing Process Go Back to the Old System Totally Flawed System Excessive Political Correctness Lack of Specificity
Flawed Concept Within the Application Process	SHO v FY Doctors Inadequate Research and Development CVs & Interviews
Application Process	IT Problems Timing Application Form Problems CVs Interview Format Information Dissemination
Military Issues	Lack of Ability to Recognise Military Medical Service Military Service Issues
DPMD Specific Issues	General Dissatisfaction Communications DCAs Roles

Narrative Evaluation – What Went Well
When assessing the positive aspects 16/42 (38%) of the responses were either blank or included a statement that there was nothing positive to say. There were 46 individual positive statements covering six different topics within three main themes: general support comments on the IT elements, DPMD and DMS specific comments.

It was noticeable that many of the positive comments were caveated with observations of some component that hadn't worked or was initially thought the best aspect hadn't been. Many knew of others who had had a more protracted process.

Everything had no problems at all with it one of my colleagues however I do know people who have had the following issues [...] crashes

I can safely say I think the process let me down

Having to go through the process as a paper work exercise was an utter waste of time. Most things could be improved

Meaningless questions bullshitters paradise selection by buzzwords not by achievement

Should have been piloted

Should have had a separate requirement for SHOs wrt FY doctors"

Ridiculous weighting of research and prior over good clinical experience and referee

Interviewers should have seen our application forms or CVs prior to interviews

[...] commenting regarding the [...] DPMD was much better than my [...] experienced

[...] RAF DCA [...] advice

Narrative Evaluation – Areas for Improvement Summary When looking at the areas for improvement only 3/42 (7%) of the forms were left blank. There were 131 individual statements covering 19 different topics within 5 main themes. General dissatisfaction. Flawed concepts within the application process. Problems with the application process. Military issues. DPMD specific issues.
The comments that were provided were longer and more emotive than those in the 'What Went Well' section. The general comments almost all expressed a strong feeling that the application system had failed the individuals.

[...] application [...] problems

[...] application

[...] support [...] application [...] DMS [...] DPMD

I found it incredible that our CVs/portfolios were not taken into account in the system. This is now acknowledged as a failing in the MTAS system in general

There was frequent criticism for the way in which the IT system failed and the way the online application forms had been designed and the lack of suitability for purpose.

The capacity of the website was far less than should have been.

"Extreme difficulties accessing the information about interviews etc.

The online application forms were very buggy ... for a system requiring a robust structure and related to medicine there were more than a few signs that it had not been properly beta tested nor reviewed by medical personnel."

150 words to express oneself adequately is unrealistic (200–300 min).

Consultants marking horizontally, have no feel for candidate."

I could not fit everything I had done into 150 words.

The application seemed to be more about how to write and do a good application than finding out about your achievements.

There was consistent criticism that the system did not allow DMS MOs to demonstrate the military specific components of their work in order to display the added value that military experiences may bring, albeit outside of an NHS hospital setting.

Took no account of Service experience and other qualifications especially to standard experience in military GDMO unit.

As military surgeons/physicians we have not been able to offer most interviewers panels that are equivalent NHS colleagues. We could not do so with the interview process.

There was no scope to expand on other experience that have had during deployments, management, being a practitioner etc.

A call for improvement in the system. Both DPMD and the DCC received a number of comments with regard to the system, often elicited to specifically ask for advising individuals where they might be successful.

Poor understanding of the system by those involved in the selection process on how to expand on the information given in the CV. Lack of feedback to candidates as to why they were unsuccessful.

More guidance and information from DPMD DCA ... [illegible] ... progression is given to candidates.

Discussion

This study has identified a number of strengths and weaknesses in the MTAS system. The response rate was low, however there are [illegible] consistencies and [illegible] findings.

Email questionnaires have the advantage of reaching individuals quickly, thereby enabling rapid dissemination of results and no costs involved. However disadvantages include a low response rate, as the researcher has no control over the reply. In this study the response rate against the number of questionnaires sent out is low. It is thought that this is due to the fact that the questionnaire was sent out to individuals who had already been successful in the application process and therefore may not have had the motivation to complete the questionnaire promptly. Another possible explanation for the poor response rate is that the questionnaire was sent out during the busy Christmas period.

Many questions [illegible] ... [illegible] ... [illegible]

poo reso [illegible] questionnaire and the [illegible] of the narrative responses. While the two methods of data collection are not independent, in that both sources of information were provided by the same individuals at the same time, having two different data sets has enabled a comparison to be conducted. It can be argued that triangulation such as this provides a further mechanism for increasing the validity of the information being assessed. It can also be of use as a mechanism of ensuring comprehensiveness and enhancing reflexive analysis, rather than as a pure test of validity (8).

Conclusions

This evaluation has identified a clear consensus of opinion amongst DMS applicants that the MTAS process has significant flaws undermining this group's ability to demonstrate their attributes and expertise. This is particularly noticeable when considering the need for the group to account for their non standard / non NHS military experiences which can be of great value in future training and is certainly of relevance for their employment.

From the DMS training perspective, DPMD remains fully committed to ensuring military trainees are able to demonstrate suitable qualities to work and train effectively within both the NHS and Service environments (including military operations) prior to the allocation to training programmes. However, DPMD does recognise the opinion from current applicants that the MTAS process is lacking on both accounts. The deanery will monitor the developments of any MTAS [illegible] for next year and consider whether additional mechanisms should be put in place to enable DMS candidates to present their Service specific skills and knowledge during the selection process.

[illegible] J P Owen MB ChB MMedSc FFOM L/RAMC

[illegible] Defence Postgraduate Medical Dean

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Clinical

The Team Works – A Multidisciplinary Challenge

C A Fries, M J Midwinter, S E P Bree, P J Taylor, M Peterson

Introduction

The design mandate of the Role 2 (Enhanced) (R2(E)) hospital is to conduct the immediate management of battle casualties. However it will occasionally be faced with patients who require long term specialist care. These patients pose a challenge requiring a multidisciplinary approach to management.

This report describes the case of an Afghan child injured by ballistic fragments suffering loss of tissue from the chest wall and severe underlying lung injury. It is presented to illustrate the principles of management of such injuries and how this must be approached in the austere environment of a field hospital in Afghanistan. In these circumstances dedicated equipment may not be available. Indeed it may have to be improvised by the trauma team to deal with problems which in civilian practice would be the preserve of the specialist.

Case Report

A 4 year old girl suffered a blast and fragmentation injury to her left chest wall during fighting in Helmand Province. She was treated by British field medics and evacuated to a British R2(E) facility where she was received by the trauma team. In the field she was found to be alert but tachycardic (160bpm) and tachypnoeic (30rpm). She was given oxygen, the wound was dressed with a first field dressing and an intravenous infusion started. On arrival at the R2(E) primary survey revealed that her haemodynamic indices had improved but that she had a large open injury to superficial wound to her left chest wall (Fig 1). A chest X-ray (CXR) showed a left-sided pulmonary contusion (Fig 2).

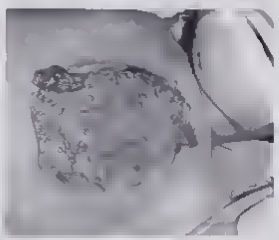

Fig 1

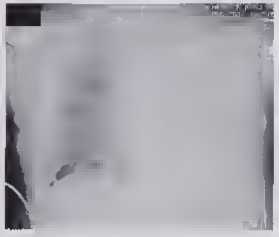

Fig 2 [illegible] left [illegible] major

Date	15-Feb	15-Feb	16-Feb	16-Feb	23-Feb	24-Feb	28-Feb
TU Day	1	1	2	4	9	9	12
Time	1730	2100	0030	0600	0900	1900	0500
FiO2	0.45	0.35	0.50	0.45	0.35	0.45	0.40
pH	7.25	7.3	7.24	7.4	7.38	7.45	7.46
pCO2	5.72	4.94	5.43	5.88	5.57	5.45	5.69
pO2	32.1	18	19.4	16.6	21	18.6	21.7
BE	-5	-6	-8	-1	-2	-6	-4
HCO3	21.1	19.3	19.3	24.1	27	31.5	31.6

On day 2 of arterial blood gases showed severe hypoxaemia and metabolic acidosis (Table 1). Abdominal ultrasound and computed tomography (CT) scan of the abdomen began to be considered and the assessment of a Focused Abdominal Sonogram for Trauma (FAST) scan and diagnostic peritoneal lavage (DPL) were performed and both were found to be positive. She continued to require no rounds of boluses and further intermittent episodes of hypoxaemia (oxygen saturations dropping to 65% on a FiO2 of 100%) and hypotension (systolic blood pressure 45mmHg). A large volume of blood was aspirated from her nasogastric tube. She responded to an increase in PEEP, increase in mode of ventilation and FiO2 of 40%. Due to worsening pulmonary overload and worsening peripheral perfusion, it was decided to undertake further emergency laparotomy. Further blood products were given and she was taken back to the operating theatre. Her abdomen was packed and she was transferred to the Intensive Care Unit (ICU) with her abdomen packed and an open abdomen (Fig 3).

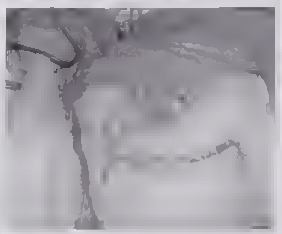

Fig 3

Two Recruitment Manoeuvres were performed by the Anaesthetist with a view to optimising ventilation. Subsequently, the patient was ventilated with low tidal volumes (6ml/kg), high respiratory rate (30/min) and an FiO2 of 100%.

Over the next few days, the patient underwent several laparotomies to control bleeding and to remove necrotic tissue. The abdomen was left open and managed with vacuum dressings. Eventually, the patient underwent a successful abdominal wall reconstruction with split skin graft and was discharged from ICU after 21 days.

The situation was [illegible] system [illegible] included and monito[illegible] pressure monitor [illegible] prevent [illegible] effective PEEP.

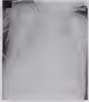

Fig 4

Her [illegible]

[illegible]

[illegible] and TEFLA [illegible]

Fig 5

Fig 6

[illegible]

split skin g[illegible] grafted f[illegible] har lam[illegible] This look[illegible] harged 35 days after a tr[illegible]

Discussion

R2(E) s sce[illegible] deal w th battle casual[illegible] casualt es w ll also be nd[illegible] t fi[illegible] ultra es ma act that co[illegible] casualt es and t[illegible] w ll eserve[illegible] pose a sign fc[illegible] resources Th[illegible] ca[illegible] case w cre[illegible] nvolved a d nuch[illegible] Staff n[illegible] e v on[illegible] sat sfy ngly t[illegible] R2 E[illegible] f osp d[illegible] n a[illegible] co[illegible]

ndarlying lung and cardiac injuries were c ve e and required management by a[illegible] as[illegible] sts and intens ve care nurses S rgery and respiratory and card ovascula pport were required to achieva a good outcome for the patient The fac lity to prov da h c after s a pre requ s te for a field hospital v h ch though not set up to treat such cases pr m ar ly none the less has a moral mperat ve to do so n some c rcumstances Tha ab lity to opt m sa tha c n cal cond t on of the pat ent us ng nt ens ve care techn ques and than n tiat t a t m ng of surgery appropriately is c t cal in ens r ng opt mat outcomes for all pat ents Tra n ng for both nurs ng c n cal and PAM staff should take nto account these extremely ch alleng ng cases that are outside the scope of what n ost m litary commander would expect or plan for

We demonst atad tha mult disc plinary approach that must be adopted n such cases Iha nput of all medical and allied med cal spec al s es work ng n the R2(E) were req r ed o manage th s pat ent

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Clinical

How many of our patients are military? A study of Emergency Department attendance at Derriford Hospital, March to August 2006

J P Despres, J E Smith L D Chilvers

Key words emergency medicine emergency nursing

Introduction

MDHU Derriford was established in 1995 and is the oldest MDHU. The Emergency Department (ED) at Derriford Hospital sees approximately 80 000 new patients per year. A percentage of these are military patients. No data currently exists regarding the attendance rate and profile (including type and reason for presentation) of military patients to the ED of an MDHU. It is not clear whether the provision of services to this specific group of patients meets current Defence Medical Services (DMS) single Service and DMETA policy. The aim of this paper was to conduct a retrospective review of all military patients attending the ED over a six month period in order to produce observational data about this group of patients.

Methods

A retrospective review was carried out of military patients attending the Emergency Department at Derriford Hospital during the period 1 March to 31 August 2006. Patients were identified using the electronic patient registration system (HAS). As there is no specific element in HAS regarding whether a patient registering is civilian or military, Service patients were therefore identified using their registered General Practitioner (individual Service sickbay) as the source. Data collected included age, gender, time of attendance, reason for attendance, outcome and follow up arrangements. These data were analysed using Microsoft Excel Professional 2003.

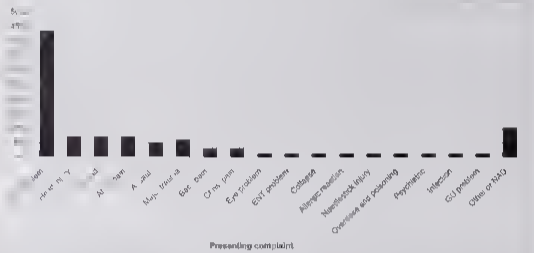
Results

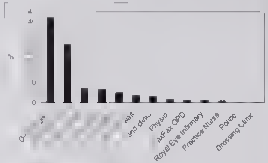
614 military patients presented to the ED during the study period, an average of 5 patients per day. This represents approximately 2% of the total number of patients attending the ED over the same period. Breaking down the attendances by month, 111 patients (n=136) attended in May and the least (n=86) in July. The average attendance at weekends was 3.3 patients per day, 84% of patients were male and the average age was 27 (range 17-50). We saw patients from 37 different nationalities.

The reasons for attendance for military patients attending the ED are illustrated in Figure 1. Of the 614 patients, 75 (12.2%) were admitted to the hospital. Table 1 shows the number (n) and percentage of admissions per specialty.

Specialty	n	% of total admissions
Emergency Department unit	16	21.3
General Medicine	15	20.0
General Surgery	14	18.7
Orthopaedics	10	13.3
Plastic Surgery	4	5.3
Maxillofacial surgery	4	5.3
Gynaecology	3	4.0
Neurosurgery	2	2.7
ENT	2	2.7
Operating Theatres	2	2.7
Coronary Care Unit	1	1.3
Intensive Care Unit	1	1.3
Oncology	1	1.3

Table 1 Admissions by specialty





Discussion

This study

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military patients

Service patients

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personnel who

an patients giving their family GP as a
ct tact
Dunford the Military Patient Admin strat o
(MPAC) s staffed between 0800 1630hrs
Fr) provid ng administrative and welfarc
ll te military patients with an on call
g a c available after hours However ar
survey of staff work ng in the ED
many civilian staff are not aware
that fa ly exists
Recommendations from this study include t
provis ot ow te g dal ce ot civilian staff

ant P De ne QARNNS ANP Emergen
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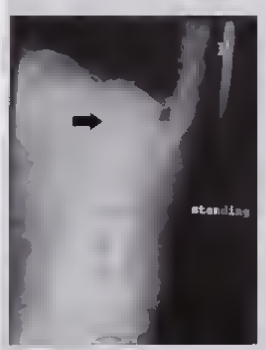
Erratum

Wild G *Vertebral Wedge Fracture after speedboat splashdown* J Roy Nav Med Serv 93(2): 75-77 2007



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Book Review

The Complete MRCGP Study Guide, Second Edition, Sarah Gear, Radcliffe Publishing, 2006 304 pages

E Mair

Despite the comprehensive sounding title, the introduction rightly explains that you cannot learn what you need to pass MRCGP from a textbook. Sarah Gear aims to provide a guide to the topics likely to come up in the exams as well as some background information. She also includes details of websites where more up to date information can be sought.

Parts 1 and 2 aim to provide a checklist of subjects which the conscientious GP Registrar should consider when studying for the written modules and to a lesser extent the oral part of the exam. Part 1 covers clinical issues and includes the classic studies and key areas of guidance as well as relevant NSFs, NICE guidelines etc. The presentation is clear with short paragraphs and bullet points covering the salient facts.

Part 2 covers non clinical issues, starting with a useful History of General Practice and probably of more use in considering topics likely to crop up in the oral exam.

Part 3 covers the exam format including changes to the new exam, nMRCGP which replaces MRCGP this year. The author provides sensible tips for preparing for the written exams and points readers in the direction of other books of sample questions. There are further tips about the online exam and examples of the types of questions as well as suggestions for ways to structure answers.

The short section relating to the MRCGP video provides almost no relevant practical information on how to pass this notoriously difficult module of MRCGP. However nMRCGP is unlikely to include an assessed video therefore this section will soon be obsolete which is presumably why she has paid it so little attention.

The book is well organised, light in weight and easy to dip into. It cannot replace attendance at VTS schemes and update courses on hot topics for military GP trainees essential courses include the GPVT or Highlands and Islands and MRCGP (soon to become nMRCGP) courses. However it provides a useful starting point for what can often seem a daunting year and does seem to be up-to-date at those taking the nMRCGP.

Author Lt Cdr Commander Emma Mair Royal Navy

Author's current appointment General Practice & Primary Care RCDM

Service News

Blood Red Dinner 2007

Speech given by Surgeon Rear Admiral P I Raffaelli OHP MSc MBBCH MRCGP FFOM

General Baxter Ladies and Gentlemen as I am sure you are all aware the year since the last Blood Red Dinner has seen a remarkable amount of change for the Royal Naval Medical Service some of which has undoubtedly been challenging April saw the decommissioning of the Royal Hospital Haslar and the final Sunset Ceremony for RNH Gibraltar will be held next Friday The RN has moved ahead with the disestablishing the 2nd MDG(N) in Fleet reducing its senior Naval management structure to one Surgeon Commodore and the review of the Defence Medical Services future manpower requirement known colloquially as the FPSG figures saw the overall RNMS requirement reducing

However it is too easy to focus on the negative We need to look at these changes in context and to recognise the huge amount of positive aspects

The Navy itself has undergone significant change in the last few years with the creation of the single Fleet Command It is now undergoing a further rationalisation through Fleet Transformation The RNMS is rightly part of this and changes in the Fleet Medical Organisation have resulted The department is now fully focussed on its principal role of support to the Fleet If you speak to people in the department they will tell you that the reorganisation has resulted in a galvanised department not only improving their outputs their value added but has significantly improved their individual jobs

I am well aware that one effect of the slimmed down hierarchy is that the RN has reduced the number of senior posts in its own right and this could make it harder for our people to compete for the Service posts There is of course truth in this but the overall rank structure is in keeping with the rest of the RN The Navy Board is acutely aware that its decision to pass on with rationalisation and training largely ahead of our sister Services may in the short term lead to some disadvantage but the First Sea Lord has given COSiP/NAVSEC and his team clear direction to seek every opportunity to identify and develop our people and to push for the creation of Service and central posts

I believe that the Navy Board's determination has been correct and any relative disadvantage will be temporary Indeed I am in no doubt that the Navy Board overall approach has played a considerable part in the positive outcome of the recent Comprehensive Spending Review for the RN and the RNMS including confirmation that we will procure the two new aircraft carriers which at 65 000 tons will be the largest ships ever sailed by the Royal Navy and a key part of modern expeditionary capability Each carrier will have an 11 man medical team and 8 bed medical suite and an operating theatre plus dental surgery The CSR has also committed £1bn to maintain the Strategic Deterrent The support to these capabilities together with the new Type 45s and the Astute Class submarines has secured the future for our three Naval Bases at Faslane Portsmouth and Devonport

In short I feel that the CSR also delivered an annual 5% saving in arm's length costs across Defence but it is work that the RN has undertaken through training places to mean an extremely strong position to minimise the effect of that requirement

If I could briefly turn to the issue of my position as MDG(N) The decision to disestablish the MDG(N) appears initially

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t have heard people ask why do we need another study or r ft sn t broken why fx t?

As part of the project the Defence Management Consultancy Service analysed pas reports on the DMS and found that only 13% ot the recommendatrons had actually beer nplemente ted In ta mass considerable prog ess has been made m deliver ng fast track healthcare and the operat onal context has been challeng ng but t s also clear that change management has not been as c“eave es r should have beam

It has also become clear dur ng th s per od ot h oh operat onal tempo and result ng battle casualr es that the notron of separatmg health care from operat onat medicat capabr ty s flawed Patient care and healthcare delr v need to be truly end to end f we ate to look after our people properly

The Project rs recommending transformation of process ownersh p governance and force generat on w th n the DMS

Surgeon General (SG) will become the overall Process Ownet of E2E Defence healthcate and med cal opetational capab l ty alk n to the role taken by the Chet of Defence Materel for Logrstics SG will be supported by a comprehensrve governance and assurance mechan sm operat ng under hrs drectron Hard driven implementatron w ll be fundamental rt we are to avo d the pitfalls o prev ous studres We will re focus one of the DMSD 2 posts es Inspector General/DG Strateg c Change to that end

Othet s gn frcant recommendat ons r clude a fundamental re organisation of DMSD and DMETA wh ch will separate st ategy and polcy from delivery DCDS(H) w ll be d sestabl shed General Baxter w ll be our third last and best DCDS(H) The 3 star SG w ll be brought under DCDS(Pers) enabl ng the DMSD ootpr nt n MB to be reduced ro tt e m n mum requ red to support M n sters and the DCMO wh ls r the DMSD Strrareg c HQ w ll be relocated to L ch f eld The DMSD Strateg c HQ w ll s t afongs de a Jo nt Med ca

Command which will be responsible for the management of all joint medical assets [illegible] the delivery of all joint medical outputs. In particular this will include a force generation capability for operations and deployments based on the centrally co-ordinated management of secondary healthcare personnel, the Defence Dental Service and medical and dental trainees. This will be facilitated by embedded manners from the single Services.

The model maintains a substantial element of sS primary care delivery and control of medical assets including INM, outside the JMS. However all elements will be under SG overall direction.

Further detail will be developed during implementation and a central contributor to this will be an independent E2E Value Stream Analysis across all Medical HQs and Directorates.

Turning back to the RNMS and its achievements over the last year – these have been magnificent. Of course, our main effort has been directed at OP HERRICK in Afghanistan and OPTELIC in Iraq where RN medical personnel provided outstanding support to Land Operations. For HERRICK 5 we provided the Medical Group Role 1 Close Support Squadron and almost the entire medical infrastructure with the exception of the Hospital squadron. While the Army had some initial reservations about our lean organisation, I believe we showed that we could more than match Army Field hospitals and medical squadrons, sorting from the impressive standards set at the Hospex and continuing throughout the deployment. It was a magnificent effort and I congratulate all who were involved.

We will be building on this success for HERRICK 9 next year, but for a significantly larger establishment with, for the first time, a RN hospital squadron which we are developing and training.

We have also been extensively involved in a range of other operations in support of the [illegible] Falkland Islands [illegible] support to the [illegible] ry of the Falkland Islands [illegible] Caribbean dependant territories and [illegible] counter narcotics operations [illegible] playing an important role in the Fleet Air Arm whose helicopters and fixed wing aircraft provide a [illegible] ultimate airborne combat capability able to operate independently at short notice in all environments, day and night, over the sea and field and all of which requires integrated medical service support.

We also continue to provide essential support to the Strategic Deterrent and SM operations. There have been a number of additional SSN taskings over the last year putting additional strain on our submarine MOs and MAs.

Exercise Medical Endeavour commences tomorrow as a component part of Exercise Grey Heron and will see over 200 medical staff and PM bandsmen embarking on RFA ARGUS. They will be exercising alongside 3 Cdo Brigade and Commando Forward Surgical Teams testing the RN's medical organisation from point of wounding through to evacuation on to the PCRF. [illegible] the exercise will [illegible] the Armed Forces, the House of Commons Defence Committee as well as 2 and 3 [illegible] from the Medical [illegible] and Commando [illegible]. This an [illegible] opportunity to showcase and [illegible] potential [illegible] ability.

We have had [illegible]

[illegible] RFA ARGUS [illegible] and Royal [illegible]

[illegible]

[illegible] or Suez on OP CALASH [illegible]

forces in [illegible] will be [illegible] the addition [illegible] ully fit [illegible] required.

During [illegible] Defence [illegible] personnel [illegible] provide [illegible] usual gaps. [illegible] y been maintained because [illegible] derable sustained additional [illegible] tions from the remaining staff at all levels. A number of PMOs have asked me to particularly mention the contribution by our primary care nurses, almost all of whom have been deployed as well, who have willingly assumed administrative and governance roles previously fulfilled by MOs. Well done.

Although the service has been maintained brilliantly, I am under no illusion that it is, and [illegible] remain, under significant strain while we continue to undertake the current level of operations. We must do all that we can to provide appropriate support to avoid creating [illegible] casualties on the home front and this [illegible] has been raised accordingly.

And of course INM has continued to provide essential specialist and scientific support to all of the above activities and to the other Services while also meeting its training role and providing specialist clinics and Boards which are now seeing over 2000 patients annually. Members of its staff were recently awarded 2 of the 6 [illegible]onal GEMS awards in the areas of health and [illegible] and environmental protection – a fair haul [illegible] establishment of 120.

INM was also the host for the MDG(N) [illegible] in July which brought together [illegible] from all branches of the RNMS and [illegible] resounding success academically [illegible] and socially and which we will repeat [illegible] year.

We also hosted the first visit of our Commodore in Chief, HRH the Duchess of Cornwall at INM last week with medical personnel also brought in from across Portsmouth. The Duchess was very enthusiastic and immensely impressed with all that she saw and the people she met. We are looking to arrange her next visit to another part of the RNMS in the not too distant future.

To conclude, this has been a challenging year but the RNMS has responded magnificently. I have no doubt that there are similar challenges ahead but I believe we are in good heart and shape and will continue to deliver. Our team certainly works.

Ladies and Gentlemen – The Royal Naval Medical Service.

Service News

MDG(N) Symposium 2007

The 3rd MDG(N) Symposium was held at the Institute of Naval Medicine on 18–19 July having been brought forward from the autumn in order to de-conflict with Exercise Medical Endeavour and the Blood Rnd Dinner.

As with previous events the four main aims were to disseminate information, provide a forum to discuss operational issues and lessons and to have fun.

The symposium was divided into 3 sessions looking at Operations, Current Issues and Updates. Following a welcoming address and introduction by MDG(N) the first session commenced with Surg Cdre Douglas Riley briefing the 25th anniversary of the Falklands Conflict with a slide presentation on relating his personal experiences during Operation Corporate. This set the scene for the remainder of the session which consisted of forenoon co-ordinated by Surg Cdr Ross Hill dedicated to medical support to Op Herrick 5. This included briefs on all elements of the organisation from Role 1 to Role 3 and an overview of the command and control structure. The personal experiences of Surg Lt Penn Bell-Walker and POMA Walton provided a graphic account of the extreme conditions under which they had to deliver medical care. The series of presentations left the audience in no doubt of the huge contribution that the RN Medical Service had delivered in support of intense and difficult operations. POMA Charlesworth provided a brief on the details and tribulations of the Sea Swap initiative currently being trialled by FLEET as part of Project Fisher (to provide flexible future manning solutions). Surg Capt Brown ended the session with a brief on FLEET deployments.

The symposium was blessed with glorious weather and the lunch break provided an opportunity for the 170 or so attendees to network in the beautifully manicured grounds of INM with an al fresco hot buffet being provided courtesy of a field kitchen from 3 Field Hospital.

The [illegible] session commenced with Surg Cdr [illegible] Operational Trauma Care. This then moved on to Surg Capt Derek [illegible] on Patient Care Pathways. [illegible] addressed some of the challenges [illegible] Operational Psychiatry. [illegible] discussed the relationship between MDHU [illegible] Network and plans to develop [illegible] to meet future lessons [illegible] issues to the co[illegible] required to ensure [illegible] in the forthcoming [illegible] Leadership was [illegible] Marriage [illegible] placed MDHU Derriford [illegible] role to follow the [illegible] people out [illegible] current plans for the [illegible] Medical Operations [illegible] (DMICP) and [illegible] and Healthy Living [illegible] delivery. The [illegible] training package [illegible] and LMA brought [illegible] outstanding [illegible] concerns. DMS [illegible] have [illegible] Defence Forces [illegible] presented [illegible] now dishonoured [illegible] of the Year Award.

With the [illegible] Symposium [illegible] stage were [illegible] The environment [illegible] be ideal [illegible] friendship [illegible] with a [illegible] MDG(N) [illegible] data [illegible] right.

concluded DMS Top Structure Next Step Project With the audience fuelled with th s nformat on MDG(N) and h s Adv sory group ded a robust and construct ve quest on J answer session before Surg Rear Adm ral ahelt gave h s closing remarks

I e nternal validat on by sympos um gates showed that that all the a ms of thi posium were ach eved and that attendees ll I ener nformed hav ng had the opportunity ss current ss es and raise quest ons l est level Equally mportant they yed the event and part cularly for many tle c v l a n joint arena t e luced t l e esp r t de corps of being part R J Med cal Serv ce

Service News

SpR/SpT Study Days 10-11 May 2007

Following the success of the previous Study Days held in the autumn, there was a great deal of interest in the follow-up meeting which was set as the focus for attendees to complete the RM Fitness Test. Other activities included presentations on clinical and diagnostic aspects of Orthopaedics, Urology, Neurosurgery and Basic Sciences pathology as well as DPA followed by an operational update from the Assistant Director Medical Operations (Navy).

A lively and informative session on operational medicine was followed by an open invitation offered to the local medical community to attend. The evening was concluded over the Royal Naval Club Chair of the Academy of Medical Royal Colleges and Fellowships (Royal College of Physicians, Royal College of Surgeons, Royal College of Anaesthetists, Royal College of Pathologists and Royal College of Ophthalmologists) was held in the Royal Naval Club. The evening was enjoyed by all those who attended and the opportunity for the Assistant Director Medical Operations (Navy) to [illegible]

Service News

HRH The Duchess of Cornwall visits INM

HRH the Duchess of Cornwall [illegible] in her official capacity as Commodore-in-Chief of the Royal Naval Medical Service, visited INM on 14 September 2007 accompanied by the Medical [illegible] General Naval Surgeon Rear Admiral Philip Raffaelli. The Duchess was received on arrival by the Medical Officer in Charge, Surgeon Commodore [illegible] Sykes and the [illegible] Lieutenant Steve Pearce [illegible]. [illegible] INM specialists [illegible] Her Royal Highness saw various [illegible] and books and visited the [illegible] commemorate [illegible] Surgeon [illegible] MVO [illegible] only member of the [illegible] Naval Medical Service [illegible] [illegible] of the establishment during which she saw the Seafield Cold [illegible] Tank and the Environmental Medicine Unit and the chamber which was [illegible] for a Heat Injury [illegible] at the time. During the visit the Duchess met many of INM's own military and civilian staff as well as [illegible] others of the Royal Naval Medical Service from nearby establishments.

[illegible] the Duchess experienced a flavour of the diversity of the Royal Naval Medical Service and the support it provides to the Royal Navy. We hope that the visit has whetted her appetite to see more and she can be assured of a very warm welcome when she returns.

HRH the Duchess of C[illegible] signing INM Visitors Book with [illegible] Rear Admiral Philip Raffaelli and Surgeon Commodore [illegible] Sykes

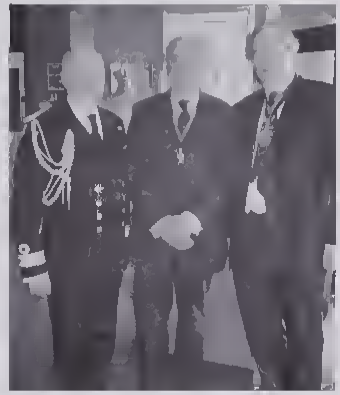
HR[illegible]

Service News

Charles Bernard Lecture 2007

It was with great pleasure that the Institute of Naval Medicine hosted the 4th Biennial Charles Bernard Lecture on 31 May 2007. The Lecture was instigated as part of the arrangements to celebrate the association of the Institute with the Barbers Company. Charles Bernard was an eminent surgeon of his day, a Master of the Company and a Sergeant Surgeon to Queen Anne.

This year's speaker was Surgeon Rear Admiral (Retired) Jack Dent, Master of the Company and Sergeant Surgeon to the Queen. Sergeant Surgeons are the Past Presidents of the Royal College of Surgeons of England. His presentation covered Sergeant Surgeons to the Barber Company and the Navy, [illegible] closely tied to the Royal Household by the Office of Sergeant Surgeon. Illustrated by many rare and historical engravings, some of which were from the Library of the Royal College of Surgeons, the lecture [illegible] Barbers, who were the [illegible] in the English [illegible] Company [illegible] Royal College of Surgeons [illegible] Sergeant Surgeons [illegible] Company [illegible] Royal College of Surgeons [illegible]



Sergeant Surgeon [illegible] replaced at the Sovereign's [illegible] enjoyed a drink with the Lord Mayor [illegible]

Service News

Citation MA of the year MA C L Bridger W148879B

MA Bridger commenced Medical Assistant training in June 2006. Right from the start it was clear that she was determined to apply herself to passing all the exams. She not only succeeded in passing all her exams but also to excel in all the subjects. She scored the Academically Distinguished Achievement award having achieved marks in excess of 90% in all her exams. She was awarded the Academic Prize for Medical Science and the Academic Prize for Clinical Medicine. She also passed all her exams at the first attempt, a feat that many struggle with.

Her academic achievements were matched by her professional standards during her Clinical Training phase of training. Her Clinical Training Reports show that she was a hardworking individual with a willingness to learn and develop her professional and clinical skills. She was praised for her ability to manage superbly with patients and staff alike. During this phase of training she managed to complete her clinical task book.

While at Royal Navy Medical Service Training Establishment Collingwood she continued in the same vein and demonstrated her learning by becoming the trainee with the highest average of 87%. A very well deserved military award was given to her by the Commanding Officer of the Defence Medical Training Establishment Collingwood. Lieutenant Colonel Davy Tipping, Director of Medical Education and Training, commented that her efficiency and professionalism during her phase 2 MA training. Currently serving with HMS OCEAN she is commended for her MEDEX Darnford. MA Bridger has now completed her Royal Navy Medical Assistant Course and Joins MA Bridger has now completed her Royal Navy Medical Assistant Course and Joins the MA of the year award.

Citation for LMA of year award LMA HOGBEN D246107

LMA Hogben joined the Royal Navy in the October 2000 intake of Naval Medical Assistant trainees at HMS Raleigh. This was immediately after completing his A levels at Royal Navy College Dartmouth. He was selected for the Medical Assistant Course at the Royal Naval School of Medical Training, HMS Sultan, in January 2001. He passed the course with distinction and was awarded the Academic Prize for Medical Science. He was then drafted to the Royal Naval Hospital Haslar where he worked in the Accident and Emergency Department, Medical Wards and Operating Theatres. He was awarded the Academic Prize for Clinical Medicine.

In January 2002 he was drafted to HMS Ark Royal and joined the Medical Department. He was awarded the Academic Prize for Medical Science. He was then drafted to the Royal Naval Hospital Haslar where he worked in the Accident and Emergency Department, Medical Wards and Operating Theatres. He was awarded the Academic Prize for Clinical Medicine.

In January 2002 he was drafted to HMS Ark Royal and joined the Medical Department. He was awarded the Academic Prize for Medical Science. He was then drafted to the Royal Naval Hospital Haslar where he worked in the Accident and Emergency Department, Medical Wards and Operating Theatres. He was awarded the Academic Prize for Clinical Medicine.

Service News

Honours, Awards and Citations

Constable and Governor of Windsor Castle

Surgeon Vice Admiral I L Jenkins CB CVO FRCS (from 1 Feb 08)

Defence Consultant Adviser

Surgeon Captain Alasdair Walker OBE FRCS Royal Navy Defence Consultant Adviser in Surgery

ARRC

Lieutenant F Kelly Royal Navy

Mention in Despatches

POMA R A Smith

CJO Joint Commanders Commendation

POMA K Smith
MA D Beardwood

Sick Berth Petty Officers' Efficiency Medal

POMA G I McGuire

Academic Achievements

Surgeon Lieutenant Commander Simon Mercer Royal Navy
Final FRCA

Surgeon Lieutenant Commander Tim Scott Royal Navy
Final FRCA

Surgeon Lieutenant Commander A R Proctor Royal Navy
MRCGP (Merit)

Surgeon Lieutenant Commander Anthony Dew Royal Navy
MRCGP

Surgeon Lieutenant Commander R J Webber Royal Navy
MSc in Occupational Health with Distinction

Surgeon Lieutenant Commander D E Ayers Royal Navy
Intercollegiate Exit Examination in Plastic Surgery

Promotion

Surgeon Sub Lieutenant to A/Surgeon Lieutenant

Surgeon Sub Lieutenant D C Angus Royal Navy

Surgeon Sub Lieutenant W J Denby Royal Navy

Surgeon Sub Lieutenant I A M Edgar Royal Navy

Surgeon Sub Lieutenant R L Fry Royal Navy

Surgeon Sub Lieutenant A L Hale Royal Navy

Surgeon Sub Lieutenant A H Heddle Royal Navy

Surgeon Sub Lieutenant R W Hughes Royal Navy

Surgeon Sub Lieutenant S Jamieson Royal Navy

Surgeon Sub Lieutenant S M T Jeffery Royal Navy

Surgeon Sub Lieutenant P J Kemp Royal Navy

Surgeon Sub Lieutenant J A Miller Royal Navy

Surgeon Sub Lieutenant S N Pillai Royal Navy

Surgeon Sub Lieutenant J J Reilly Royal Navy

Surgeon Sub Lieutenant M W Robinson Royal Navy

Surgeon Sub Lieutenant A T H Shaw Royal Navy

Surgeon Sub Lieutenant S D P Tolve Royal Navy

A/Surgeon Lieutenant to Surgeon Lieutenant

A/Surgeon Lieutenant C Bleakley Royal Navy

A/Surgeon Lieutenant S J N Boutin Royal Navy

A/Surgeon Lieutenant C V Evans Royal Navy

A/Surgeon Lieutenant J T Evans Royal Navy

A/Surgeon Lieutenant T P Herod Royal Navy

A/Surgeon Lieutenant A H Hewitt Smith Royal Navy

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Royal Navy

Surgeon Lieutenant to Surgeon Lieutenant Commander

Surgeon Lieutenant B M Pointon Royal Navy
Surgeon Lieutenant S A Miles Royal Navy
Surgeon Lieutenant M A Cordner Royal Navy
Surgeon Lieutenant J C Phillips Royal Navy
Surgeon Lieutenant A M Wood Royal Navy
Surgeon Lieutenant E C Allcock Royal Navy
Surgeon Lieutenant R E F Ambrose Royal Navy
Surgeon Lieutenant A M Edward Royal Navy
Surgeon Lieutenant T E Evans Royal Navy
Surgeon Lieutenant R Hemingway Royal Navy
Surgeon Lieutenant C R Hunter Royal Navy
Surgeon Lieutenant R J Kershaw Royal Navy
Surgeon Lieutenant C R Picken Royal Navy
Surgeon Lieutenant V S Swindells Royal Navy
Surgeon Lieutenant R S Taylor Royal Navy
Surgeon Lieutenant A J Vale Royal Navy
Surgeon Lieutenant R W Westerman Royal Navy
Surgeon Lieutenant A E Gregory Royal Navy

Surgeon Lieutenant to Surgeon Lieutenant Commander (D)

Surgeon Lieutenant Commander (D) J P Wells Royal Navy

Surgeon Lieutenant Commander (D) to Surgeon Commander (D)

Surgeon Lieutenant Commander (D) C J E
Royal Navy
Surgeon Lieutenant Commander (D) P G Mo
Royal Navy

A/Surgeon Captain (D) to Surgeon Captain (D)

A/Surgeon Captain (D) M Gall Royal Navy

Sub Lieutenant to Lieutenant

Sub Lieutenant D Cummings Royal Navy
Sub Lieutenant D P Humphrey QARNNS

Transfer of Commissions

Placed on Retired or emergency lists

Surgeon Commodore P F R Tolley Royal Navy
Surgeon Captain O M Howard Royal Navy
Surgeon Lieutenant Commander S A F J Bennett Royal Navy
Surgeon Lieutenant R M Westerman
Commander C J Lloyd Royal Navy
Lieutenant P E Simpson Royal Navy
Lieutenant S E Gray QARNNS

Royal Naval Medical Branch in Nuclear Submarines The RN Submarine Museum has identified a gap in its archives regarding the early involvement of the RNMS in nuclear submarines and has asked Cdr Bill Nimmo-Scott if he could compile a suitable archive which could be used as a reference point when people are researching this particular aspect of Naval history some time in the future. Bill is looking for anything which might help in this such as personal reminiscences, commissioning books photographs or other memorabilia. Please contact Bill at billnimmoscott@ftrellyuk.net or tel: 01672 810751

Obituary

Surgeon Captain Murdo Macleod Royal Navy (1935 – 2007)

Surgeon Captain Murdo Macleod died peacefully at home on the morning of Monday 25th June. Murdo had been suffering from Parkinson's disease for some time. He was overwhelmed by the kindness and devotion of his wife Ann and family during his illness.

Born in Glasgow on 11th December 1935, Murdo graduated MB ChB from the University of Edinburgh in 1960. He joined the Royal Navy as a Surgeon Lieutenant in 1962. He served in a number of Royal Naval establishments and ships including HMS Dolphin, the Submarine Base at Faslane, HMS Eagle, the Royal Naval Hospital Haslar and HMS Bulwark. He was promoted Surgeon Commander in 1976 and Surgeon Captain in 1987. He retired from the Royal Navy in 1995 and worked for 5 years as a Civilian Consultant in Nuclear Medicine.

Murdo's specialty training was in Nuclear Medicine. He was appointed Consultant in Nuclear Medicine in 1977 and was Director of Nuclear Medicine at the Royal Naval Hospital Haslar from 1978 where he developed a sizeable reputation. He was appointed Head of Department and Senior Adviser until his retirement as Surgeon Captain in 1987. Murdo continued to work for the Royal Navy in 1995 and for a further 5 years as a Civilian Consultant in his specialty.

Murdo held a sizeable reputation. He left a colourful years as President of the Annual Mess in 1985. As those who knew Murdo was an extremely character. He was

Alex J. Houston

laid to rest by many as a testament to the man and a legend in his time. Despite never having doubt he enjoyed. It has to be said that his notion of socialising at high level sometimes differences did not meet with universal approval and the stories that have been told over the several volumes. The promotion of Murdo rides the fact that he was a very knowledgeable in his field, where conservative innovator who also encouraged innovation in others. He was an excellent motivator and was loved and respected by everyone who worked for him. Murdo was mainly responsible for making a small provincial medicine department known and respected throughout the world.

He was very much a man of his time, doing all forms of political correctness. For his patients he considered benefit ahead of risk, which he firmly believed to be negligible in diagnostic nuclear medicine. He was proud that his department offered innovation and individuality rather than conformity with others. He had superb instinct and was quite brilliant at making instant decisions, many of which would now involve a lengthy process. Invariably his decisions turned out to be correct.

On a personal level, Murdo loved life and lived it to the full. He was extremely proud of his Scottish Highland roots, spoke Gaelic, enjoyed his malt whisky and would sing Scottish songs to anyone who would listen. He supported Glasgow Rangers and was a very decent footballer in his day. He was generous to a fault and was fiercely loyal to his friends.

In short, Murdo was a legend, a one-off character who will be sadly missed by his family, his colleagues and his many military friends from the Royal Naval Medical Service.

Surgeon Commander Ian Riddell MD MBE Royal Navy 1950 - 2007

Ian died [illegible] Glen Lyon o[illegible] August [illegible] 07 [illegible] known [illegible] Dr [illegible] excellent [illegible] many parts [illegible] man who [illegible] the hills of [illegible] loved Glen Lyon [illegible] naturalist and environmentalist [illegible] doctor and a [illegible] family man. His brother [illegible] Lieutenant Colonel Roddy Riddell [illegible]

For the last [illegible] Ian, or as he was almost always known by the family Iane, had not been well. We had all seen a steady deterioration in health but even then his sudden and unexpected death came as a shock. It is hard to believe that someone you grew up with who was so full of knowledge about so many subjects and who had such a great vitality [illegible] our lives.

Iane was the second of 5 [illegible]. We had a very happy childhood in [illegible] Glasgow but Glen Lyon where Granny and Grandpa Molteno lived became a strong influence in all our lives. The freedom to roam the hills and [illegible] swimming in the Lyon [illegible] August picnics with Mum and Dad and often our cousins, skating on the [illegible] the Roman Camp and [illegible] gave us all a great love of the outdoors and [illegible] nature. Iane carried this [illegible] has passed it on to his sons.

We all went to Bel[illegible] on the outskirts of Glasgow [illegible] an undistinguished [illegible] I can still see [illegible] bottom of a sc[illegible] bespattered 12 year old gripping the bal[illegible]

He moved to Loretto School [illegible] in 1963. Not unintelligent, he [illegible] keep the masters satisfied. His own [illegible] knowledge of birds was [illegible] at Loretto. Each winter the [illegible] of Forth were invaded by thousands of waders and ducks. He became quite an expert on all the different bird species as well as enjoying a crafty fag away from prying eyes. Iane was not an angel and was described in one report by the

[illegible] and was very [illegible]

[illegible] Lyon Co[illegible] We spent [illegible] [illegible]

[illegible] Royal Navy [illegible]

[illegible]

[redacted] attention. The success rate of getting these injured back into training was largely due to his diligence and attention to detail. It also proved a major factor in keeping the morale of [redacted] recruits up when they felt left behind on [redacted] their colleagues complete training [redacted] they could do so themselves.

[redacted] became a key member of the Recruit Training Working Group making a significant contribution through devising ways to reduce injuries. His constant support and advice [redacted] was important to the Centre and Commando [redacted]. One in particular which I had the [redacted] Commando at that time. Woodbury [redacted] Training Exhaustion were also problems [redacted] that was significantly reduced by [redacted] innovative advice and management [redacted].

[redacted] was a true and truly [redacted] and caring doctor. He was [redacted] with [redacted] to contact with making [redacted] aware of their flank or status. He [redacted] sky-med conditions in plain English [redacted] Scottish and was rarely flustered [redacted] tea pot and pen and writ pen in hand [redacted] often the life and soul of a party.

[redacted] cold weather [redacted] 45 Cdo RM [redacted] unrivalled expert [redacted] how to prevent the [redacted] MBE and gained his Medical Doctorate for his research in this area. This was an era when the Soviet threat was very real and the defence of the Northern wastes of Norway was crucial to deterrence and therefore the ability to fight in the Arctic and survive was paramount. Ian did much to advance the Royal Marines skills in this very testing and harsh environment.

At CTCRM Ian gave his personal attention to everybody he dealt with. He knew by name the vast majority of those who passed through his hands and they had the greatest respect for him. He was also responsible for those with longer term injuries and who required remedial training before returning to training. Ian gave this important area his utmost attention. The success rate of getting these injured back into training was largely due to his diligence and attention to detail. It also proved a major factor in keeping the morale of recruits up when they felt left behind on injury their colleagues complete training [redacted] they could do so themselves.

[redacted] became a key member of the Recruit Training Working Group making a significant contribution through devising ways to reduce injuries. His constant support and advice [redacted] was important to the Centre and Commando [redacted]. One in particular which I had the [redacted] Commando at that time. Woodbury [redacted] Training Exhaustion were also problems [redacted] that was significantly reduced by [redacted] innovative advice and management [redacted].

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Others have commented level headed rapport with seniors juniors and patients alike intelligent industrious conscientious an exceptionally fine PMO professional infectious enthusiasm single minded and dedicated in the way he pursues medical data to rectify the main stresses and elements of basic training a remarkable man with an engaging personality who is an asset to those who serve with him and all done with engaging good humour.

For all who knew him Ian was a truly wonderful and caring man a most impressive professional compassionate and much loved Commando Doctor. He will be sorely missed by all who knew him particularly his wife June and his two sons Michael and Niall to who we extend our deep sympathy.

[redacted] Rod Roddy Riddell and Mike Hunter

[redacted] has been received of the death of the following:

Surgeon Commander (D) W Grove-Smith Royal Navy

The editor would welcome any words in memory of him.

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upon [illegible] Service [illegible] reports [illegible]

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Manuscripts must be in English in a form suitable for publication as a original oral presentation. **Uniform Requirements For Manuscript Submitted to Biomedical Journals** (N Engl J Med 1997 **336**(4) 309-15) gives guidance. Scientific papers should be prefaced with an abstract of the hypothesis argument and findings. This should not exceed 150 words. Headings within the text should be used to highlight the content of different sections. Where possible manuscripts should be prepared in Microsoft Word on CD or floppy disc. Otherwise they should be typewritten in double spacing on one side of A4 paper. The author should retain a copy of the disc/manuscript.

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The title page should contain a concise informative title up to five key words the names and initials of all authors and their appointments and the department(s)/institution(s)/shp(s)/establishment(s) where the work was carried out.

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Tables and illustrations (figures) should add to the paper rather than only repeat information presented in the text. Each table and illustration should be on an individual page separate from the text be numbered in two distinct sequences in the order in which they are mentioned in the text and have an explanatory caption (typed on a separate sheet for illustrations).

News photographs of academic social sporting or other occasions involving members of the Royal Naval Medical Service are welcomed. Normally printed illustrations will be monochrome. The views of the Editor should be sought where colour illustrations is thought to be essential or highly desirable. Photographs must be of good quality glossy unmounted and be provided in camera-ready form with redundant areas trimmed off. The figure number authors name and top/bottom should be marked on the back. Line drawings should be professionally drawn and labelled or of equivalent standard and submitted as photographic prints or high quality photocopies. Lettering and numbering should be sufficiently large to ensure legibility after reduction for publication. Freehand lettering is not acceptable.

Measurements and abbreviations

Measurements should be given in the units in which they were made but with the exception of blood pressure in mmHg and haemoglobin concentration in g/dl non-metric units must be accompanied by metric (SI) equivalents. The approved name of drugs should be used (proprietary names may follow in parentheses). If an abbreviation is used the term (or which it stands should be given in full at its first mention in the text e.g. Institute of Naval Medicine (INM).

References

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Acknowledgements

The assistance of those who are not authors but made substantial contributions to the study and/or preparation of the paper should be acknowledged as should the source(s) of grant support equipment drugs facilities etc.

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